Rescue Union School District
Educating for the Future, Together

FOOD ALLERGY/SENSITIVITY HEALTH PLAN

Insert Student Photo

Student Name: _____ Grade: _____ DOB: _____

School Site/Teacher: _____

Allergen(s): _____

Reaction: _____

_____

→ *For severe reactions or any concern for anaphylaxis please use "Allergy & Anaphylaxis Health Plan."* ←

Food allergy symptoms usually develop within a few minutes to 2 hours after eating the offending food. Rarely, symptoms may be delayed for several hours. Mild symptoms can include: Abdominal pain, diarrhea, nausea, vomiting, and sometimes headache or brain fog.

ACTIONS TO BE TAKEN AT SCHOOL WITH KNOWN OR SUSPECTED EXPOSURE:

☐ Medication at school: _____
Any medication being administered at school requires a medication form that is updated at least annually.
If prescribed Epinephrine (Epi-Pen), please fill out the "Allergy & Anaphylaxis Health Plan" In place of this form.

☐ Other: _____

☐ Complete the "Meal Accommodation Form" if school provided meals are requested (see back of this form).

☐ Notify Emergency Contact

EMERGENCY CONTACTS:

Mother/Father/Other: _____ Contact #: _____

Mother/Father/Other: _____ Contact #: _____

Parent/Guardian (name/signature): _____ Date: _____

Reviewed by Health Office (name/signature): _____ Date: _____

Reviewed by District RN (name/signature): _____ Date: _____

Resources: May Clinic 2023.

MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner. The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.**