PLYMOUTH COMMUNITY SCHOOL CORPORATION

FOOD ALLERGY / INTOLERANCE PRESCRIPTION

August 2007

Dear Parent/Guardian:

You indicated to the school that your child has a significant food allergy or intolerance that could require *emergency treatment* while in school. In order to insure the best possible treatment plan, the Food and Nutrition Services Department must have a **written prescription from your doctor** (see below) to help avoid the food(s) that produce an allergic reaction or intolerance in your child.
Please return the information to the school nurse as soon as possible.

Student's Name____

Date of Birth__________________ Grade_______________________ Room_______________________

FOOD (check which applies) ☐ Allergy ☐ Intolerance

1.___________________________________ 2.___________________________________

3.___________________________________ Other________________________________

Symptoms demonstrated by the student:____

I authorize that the above named child is allergic/intolerant to the food(s) listed, may *require emergency treatment* and that the food(s) should be avoided.

☐ Suspected ☐ Documented

☐ PCSC Food Service will determine the appropriate food substitution

Physician's Signature__________________________ Please print name____________________________

Telephone ____ Date___________

I have read, reviewed and understand the food allergy/intolerance information formulated by my child's physician. I agree that it may be placed on file as a part of my child's school health record and the necessary information be shared with PCSC Food and Nutrition Services and my child's teacher and staff. PCSC Food and Nutrition Service is permitted to contact my child's physician to obtain further explanation of the above information. This authorization is in force for the current school year unless I submit new information in writing to the school.

Parent's Signature____ Date___________

Date mailed/given to parent_____________________________

☐ Copy to Food Service Date__________________

☐ Copy to Teacher Date__________________

☐ Original in Student Health Record Date__________________

Signature of School Nurse_____________________________________