Food Allergy Notification and Medication Order Form

This form is to be completed by a licensed physician (or other medical authority) for ***students who have been diagnosed with a life threatening food allergy or a disability and requires a special diet or food accommodation****. Please note, an individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well asthe USDA's nondiscrimination regulation, as aperson who has physical or mental impairment that substantially limits one or more major life activities that allreasonable requests for food and beverage substitutions will be made so the student can eat.*

PART I - Parent/Legal Guardian to complete this section: **Student Grade:________** **Student ID#_______** **Sex:** M F

Student Last Name___________________________Student First Name____________________School Building____________

Parent/Legal Guardian Name (s)____ Phone # ___________________________

Parent/Legal Guardian Name (s)____ Phone #____________________________

Parent/Legal Guardian Email Address: ____________________________________

Which of the above numbers is the best way to contact with questions? ☐ Phone ☐ Email

****PART II, III & IV BELOW MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN/MEDICAL AUTHORITY ****

PART II - To be completed by licensed physician or medical authority any time there is a change in the diagnosis regarding food allergies on this student.

Please check all FOODS to be avoided by this student in order to prevent a life-threatening reaction:

☐ Eggs ☐ Dairy ☐ Soy ☐ Peanuts ☐ Tree Nuts ☐ Wheat ☐ Fish ☐ Seafood

Other Food (s): (Please specify)____

Please list the appropriate foods to substitute for the allergen-containing foods listed above:

PART III - To be completed by licensed physician or medical authority any time there is a change in the diagnosis regarding a disability for this student.

Student's Disability:	
Brief Explanation of why the disability restricts the student's diet:	
Please identify the major life activity affected by the disability:	

Physician Signature:	Date Signed:
Printed Name of Physician:	Doctor's Office Phone #:

PART IV – Medication Orders Related to Food Allergy

District policy requires consent of the parent/legal guardian and a written order from the doctor before medication can be given to a school by school personnel. This includes over-the-counter medication. Medication must come to school in the original container with the affixed label from the pharmacist. Prescription medication must show: Student's name, name of medication, dosage instructions, licensed prescriber's name and prescription number (if there is one). New medication must be provided should the current medication expire, this is the parent's responsibility. A written order from the physician is required for a student to carry an inhaler or Epi-Pen. The following information must be completed below in order to comply with this district policy.

Medication	Dosage	Time	Duration	Route	Side effect (s) to notify physician upon

CHECK BOX IF STUDENT HAS BEEN TRAINED AND MAY CARRY OWN EPINEPHRINE AUTOINJECTOR and/or INHALER

Physician Signature: Date Signed:

*****PARENT CONSENT REQUIRED FOR THIS FORM TO BE FILED*****

PARENTAL CONSENT: I give my permission for the principal, or his/her designee, to administer the medication as prescribed above to my child, for the sharing of this information with appropriate district staff (this includes but is not limited to administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches and substitute employees). I also agree TO THE FOLLOWING: Notify the school if the medication or dosage is changed or discontinued; Grant permission for the school nurse to confer with the doctor regarding health and treatment issues as they pertain to the above medications and or diagnosis as related to his/her educational and behavioral management needs; Provide safe transportation of the medication to and from school to a school official and to provide a back-up dose of Epinephrine (if medical authorization is given above per Ohio Revised Code 3313.718).

Signature of Parent/Guardian____ **Date** _______________

Tippecanoe School Corporation Use Only:

SIGNATURE OF PERSON(S) AUTHORIZED TO GIVE MEDICATION

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ADMINISTRATION APPROVAL:

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