

SGCC FOOD ALLERGY FORM

(This form is to be completed for a diagnosed food allergy only, not a food intolerance.)

ALLERGY TO: _____

CHILD'S NAME _____

DATE OF BIRTH _____

ASTHMATIC (Circle) YES NO



My child may experience one or more of the following:

SYMPTOMS: (Please check)

___ Itching & swelling of the lips, tongue or mouth

___ Itching and/or sense of tightness in the throat, hoarseness, and hacking cough

___ Hives, itchy rash, and/or swelling about the face or extremities

___ Nausea, abdominal cramps, vomiting, and/or diarrhea

___ Shortness of breath, repetitive coughing, and/or wheezing

___ "Thready" pulse, "passing out"

ACTION:

If ingestion is suspected, give _____
medication/dose

and _____ immediately!
course of action

PHYSICIAN'S NAME _____ PHONE NUMBER _____

PHYSICIAN'S SIGNATURE _____ DATE _____

I give permission for the St. Gabriel Child Care staff to administer the above medication if necessary, and follow the course of action as directed by the above-named physician. I also understand that a daily permission note must be submitted (as per the SGCC handbook).

PARENT'S SIGNATURE _____ DATE _____

FOR CHILDREN WITH MULTIPLE FOOD ALLERGIES, USE ONE FORM FOR EACH FOOD.