Merrill Area Public Schools

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www.mapsedu.org

*** Student Achievement * Community Partnership * Future Success ***

FOOD ALLERGY / INTOLERANCE PLAN
School Year: 2023-2024

Student's Name: ____ **Date of Birth:** __________________

School: _______________________________ **Grade:** _______ **Teacher:** _________________________

Food Allergen / Intolerance: (*Check all that apply)*

_____Fruit / Vegetable Specify: _________________________________
_____Dairy Products Specify: _________________________________
_____Gluten Specify: _________________________________
_____Other Foods Specify: _________________________________

Food reaction happens when my child is exposed to: (*Check all that apply)*

_____Fresh foods
_____Processed foods containing the food ingredient
_____Cooked foods containing the food ingredient
_____Other - Describe: ____

My child can touch the food without a reaction. _____ Yes _____ No
My child can have limited amounts of listed foods at school. _____ Yes _____ No
My child can self-monitor the foods they eat. _____ Yes _____ No

Symptoms of child's food allergy / intolerance include: (*Check all that apply)*

_____Nausea
_____Diarrhea
_____Behavior changes - moody, irritable
_____Vomiting
_____Cramping and/or abdominal pain
_____Other - Describe: ____________________________

Onset of symptoms after ingestion:

_____Immediately
_____Within one hour
_____Within 15 minutes
_____Up to two hours

Food allergy / intolerance plan: (*Check all that apply)*

_____Call me if my child exhibits any symptoms listed above after eating the food allergen.
_____Observe my child for 30 minutes in the office.
_____Give medication to my child. Observe my child for an additional 20 minutes. Call if symptoms do not resolve.

Medication Orders

Medication	Dosage	Time/Frequency

I give permission for school personnel to administer the above listed medication(s) as ordered to my student for the duration of the current school year. I give permission to share this information with staff on a need to know basis. ***(Signatures required for medication to be administered at school.)***

Parent / Guardian Signature: ____ **Date:** _____________

Parent / Guardian Address: _______________________________ **Phone Number:** ______________

Physician Signature: ____ **Date:** ______________

Physician Address: ______________________________________ **Phone Number:** ______________