Allergy and/or Dietary Restriction Form

Child's Name
Date of Birth
Health Disclosure ☐ Allergy* ☐ Dietary Restriction ☐ Religious Preference
Description of child's special dietary restriction

CHILD'S PHOTO HERE

**If your child has known allergy, please have your healthcare provider complete the highlighted sections below.*

Description of Allergy / Condition (What physical symptoms does the child exhibit when this food is ingested or if the child comes in contact with this item?)	
Date of last reaction	Action Taken

Please circle all allergy symptoms child has ever experienced

Mouth	Itching and swelling of lips, tongue or mouth
Throat	Itching and / or sense of tightness in the throat; hoarseness; hacking cough
Skin	Hives; itchy rash and / or swelling around the face, arms or legs
Stomach	Nausea, abdominal cramps, vomiting or diarrhea
Lung	Shortness of breath; repetitive coughing; wheezing
Heart	"Thready" pulse; passing out

Treatment Plan: (Specific action to be taken if child comes in contact with this food / item

Name of Medicine _____

Prescription Number _____ Expiration Date_____

Location of Medication in Building _____ Can be kept in school office

_____ Should be kept in classroom for urgent administration

Dosage Instructions _____

Route of Delivery _____

Physician's Stamp

Physician's Signature	Date

I hereby request that Moon Valley Prep, through it'd designated authority, to administer mediation according to the above instruction. I release the school and any school employee from any liability for administering the medication.

Parent's Signature	Date

Form must be updated annually or anytime information verified by a physician changes.