

**MOSINEE SCHOOL DISTRICT
FOOD SENSITIVITY/INTOLERANCE
INFORMATION & TREATMENT FORM**

Food sensitivity/intolerance has been noted to be a concern for your child. Please provide additional information regarding your child's reaction(s) to this food.

Student: _____ Grade: _____

Physician: _____ Clinic: _____

Food or foods sensitive to/intolerant to: _____

If you feel your child's food sensitivity/intolerance is no longer a medical concern for the schools, please check the following box, sign below, and return this form to school for our records.

My child's food sensitivity/intolerance is not currently active. He/she is not under treatment for this condition.

Signature: _____ Date: _____

My child's reaction to this/these foods includes:

Nausea, stomach upset, indigestion

Abdominal discomfort, cramping, diarrhea

Facial /mouth itching

Other Describe: _____

The symptoms above occur:

Almost immediately

Within a few minutes

Within 30 minutes to 2 hours

My child has been seen by a doctor for his/her allergy: yes no

Treatment my child usually receives for his/her reaction: _____

If my child eats the food he/she is sensitive to while at school, the following treatment should be given:

Call parent/guardian to send home if experiences abdominal cramping/diarrhea

Give over-the-counter medication (not prescription) as follows*:

Name of medication: _____

Amount /dosage: _____

*** Over-the-counter medication must be sent to school with a completed upper portion of the Medication Authorization Form (see reverse).**

Provide additional instructions regarding classroom snacks, treats, cold lunch, hot lunch program, etc.:

Parent/guardian signature: _____ Date: _____



MOSINEE SCHOOL DISTRICT PARENT / PRACTITIONER MEDICATION AUTHORIZATION

(Practitioner includes physician, dentist, podiatrist, optometrist, physician assistant and advanced practice nurse practitioner per 2001 Wisconsin Act 83.)

ALL medications given at school must have written permission by the parent/guardian. ALL **prescription** medication given at school, including students who carry and self-administer inhaler and Epi Pens, must have written instructions signed by the practitioner AND the parent/guardian. No practitioner signature is required for over-the-counter (non-prescription) medication *providing* the dose is within the manufacturer's guidelines and does NOT contain aspirin.

Student Name: _____ Birthdate: _____ Grade: _____

Medical Diagnosis(es) _____

Medication(s)	Dosage & Route	Times Given at School	Specific Instructions

Medication order effective from: _____ until: _____

SELF-CARRY MEDICATION SECTION

Student can correctly use his/her medication? Yes No

Inhaler for breathing conditions: May carry self-administer? Yes No

Epi Pen for severe allergic reaction: May carry self-administer? Yes No

Insulin for diabetes: May carry self-administer: Yes No

Other medication: _____ May carry self-administer? Yes No

PRACTITIONER SIGNATURE SECTION

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Practitioner Signature: _____

Practitioner Name, Address, Phone: _____

Date: _____

PARENT/GUARDIAN SIGNATURE SECTION

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my son/daughter according to the instructions stated above and authorize them to contact the practitioner, if necessary.

Parent/Guardian Signature: _____

Date: _____

It is understood that:

1. All medications must be in an original container. Original pharmacy container must include the student's name, name of medication, dose, and time of administration on the label. Over-the-counter (OTC) medication must be in the original bottle/box/container and must include dosing instructions (quantity and frequency of administration with age). Meds sent in baggies, Tupperware, etc. will NOT be given.
2. Whenever possible, medication will be administered at home, before and/or after school hours.
3. Whenever there is any change in instructions for the above medication/s, a new form MUST be completed. A new form must also be completed for each and every school year.
4. Students who self-carry medications are responsible for taking these medications on all field trips.
5. Students will be sent by rescue squad to the emergency room after using an Epi Pen or Glucagon.