MOSINEE SCHOOL DISTRICT
FOOD ALLERGY INFORMATION AND TREATMENT FORM

Food allergy has been noted to be a concern for your child. Please provide additional information regarding your child's reaction(s) to this food so that the Health Office can follow the safest measures should an allergic reaction occur at school.

Student: ______________________________ Grade: __________

Physician: ____________________ Clinic: ____________________

Food or foods allergic to: ______________________________

If you feel your child's food allergy 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 or allergy 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 swelling, itching, welts or hives, generalized body flush
- ❑ Swelling of lips, nose tongue or throat, hoarseness, breathing and/or swallowing difficulty

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 has received for his/her last allergic reaction: ______________________________

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If my child contacts the food he/she is allergic 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: ______________________________
- ❑ Child must have adrenalin (epi pen or ana kit)*
  - ❑ Immediately
- ❑ If symptoms occur. Describe symptoms: ______________________________

  ____

  Note: If epi pen or ana kit is administered, 911 will be called.
- ❑ Student can administer own epi pen/ana kit.

***Medication must be sent to school with a completed Medication Authorization Form (see reverse). Prescription medications (such as epi pens or ana kits) also require a doctor's signature.**

Additional instructions regarding snacks, treats, lunch, hot lunch program, etc.: ______________________________

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Parent/guardian signature: ______________________________ Date: __________

Form 80 (1-99)

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.