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| CCS-logoweb | **Spokane Head Start /ECEAP/EHS****NUTRITION DIET REQUEST:** **FOOD ALLERGY/INTOLERANCE** |
|  |
| Site/room |       | FSC |       |
| Child’s name |       | Date of birth (mm/dd/yyyy) |       |
| Parent/guardian |       | Phone |       | Cell/work |       |
| Health Care Provider treating food allergy/intolerance/reaction |       | Phone |       |
| Do **you think** your child’s food allergy may be **life-threatening**? [ ]  No [ ]  Yes |
| Did your child’s **health care provider tell you** the food allergy may be **life-threatening**? [ ]  No [ ]  Yes(If YES, an Individual Health Plan will need to be in place before your child attends school.) |
| **CURRENT STATUS** Check the foods that have caused an allergic reaction: |
| [ ]  Fluid milk[ ]  Milk cooked in foods[ ]  Milk/cheese-based soup[ ]  Cheese[ ]  Cheese cooked in foods[ ]  Yogurt[ ]  Cottage cheese[ ]  Cream cheese[ ]  Margarine[ ]  Trace amounts of milk in foods such as bread[ ]  Mayonnaise[ ]  Eggs[ ]  Pancakes (contains milk, egg and soy)[ ]  French toast (contains milk, egg and soy)[ ]  Waffles (contains milk, egg and soy)[ ]  Muffins (contains milk, egg and soy)[ ]  Eggs cooked in other foods. Please list       [ ]  Soy products including soy oil, hydrolyzed or textured vegetable protein (H or TVP), soy sauce, soybean flour, etc.  | [ ]  Soy Cheese [ ]  Soy Yogurt[ ]  Wheat[ ]  Gluten[ ]  Peanuts[ ]  Foods manufactured in a plant that processes peanut containing foods[ ]  Peanut or nut oils[ ]  Peanut or nut butter[ ]  Peanut flour[ ]  Tree nuts (walnuts, almonds, pecans, etc.)[ ]  Fish/shellfish[ ]  Citric acid[ ]  Citrus fruits including oranges, canned Mandarin oranges and grapefruit[ ]  Pineapple[ ]  Berries including strawberries, blueberries, raspberries or blackberries[ ]  Juices including orange, pineapple, apple or grape[ ]  Tomatoes including sauce and ketchup |
| Please list any others |       |
| What do you use as a substitute for milk, cheese, or yogurt? |       |
| **TRIGGERS, SYMPTOMS, AND ACTION PLAN** |
| **My child will have a reaction** *(Check all that apply)* |
| [ ]  Eating foods [ ]  Touching foods [ ]  Smelling foods [ ]  Other, please explain |       |
| **How quickly do the signs and symptoms appear after exposure to the food(s)?** |
|       | Seconds |       | Minutes |       | Hours |       | Days |
| What are the signs and symptoms of your child’s reaction? |       |
|  |
| What should staff do? |       |
| Do you want staff to notify you? [ ]  Immediately [ ]  Upon pick up [ ]  Other  |       |
| Parent/guardian signature |       | Date |       |
| **Original in child’s file** | **Copy to Nutrition Specialist** | **Copy to parent** |
| **For staff use only** | [ ]  Health Specialist notified  | [ ]  IHP in place  | [ ]  IHP needed |