

WHITKO COMMUNITY SCHOOLS

710 N SR 5 – Suite B
 Larwill, IN 46764
 (260) 327-3677 | (574) 594-2658
 www.whitko.org

Dear Parent/Guardian:

You indicated to the school that your child has a significant food allergy or intolerance that could require emergency treatment while in school. In order to insure the best possible treatment plan, **a written prescription from your doctor** (see below) is required. Please return this information to the School Nurse as soon as possible.

Students Name: _____ Date of Birth: _____

School: _____ Grade: _____

Allergy:	<input type="checkbox"/> Documented Allergy <input type="checkbox"/> Suspected Allergy <input type="checkbox"/> Epi Pen Ordered <input type="checkbox"/> Special Seating <input type="checkbox"/> Hospitalized <input type="checkbox"/> Intolerance Only <input type="checkbox"/> Other Meds <input type="checkbox"/> No Special needs
Allowable Substitution:	
Allergy:	<input type="checkbox"/> Documented Allergy <input type="checkbox"/> Suspected Allergy <input type="checkbox"/> Epi Pen Ordered <input type="checkbox"/> Special Seating <input type="checkbox"/> Hospitalized <input type="checkbox"/> Intolerance Only <input type="checkbox"/> Other Meds <input type="checkbox"/> No Special needs
Allowable Substitution:	
Allergy:	<input type="checkbox"/> Documented Allergy <input type="checkbox"/> Suspected Allergy <input type="checkbox"/> Epi Pen Ordered <input type="checkbox"/> Special Seating <input type="checkbox"/> Hospitalized <input type="checkbox"/> Intolerance Only <input type="checkbox"/> Other Meds <input type="checkbox"/> No Special needs
Allowable Substitution:	

The documented food allergy listed above may require Emergency treatment and should be avoided. I understand and authorize NACS Nutrition Services' to provide the appropriate food substitutions as determined by the physician.

Signature of Physician: _____ Date: _____

Name of Physician: _____ Contact Number: _____

I have read, reviewed and understand the food allergy/intolerance information formulated by my child's physician. I agree that it will be placed on file as a part of my child's school health record and the necessary information is shared with NACS Nutrition Services, my child's teachers and school staff. I understand that only the meal modifications/substitutions prescribed above by the physician will be made for my student. I understand that NACS Nutrition Services are permitted to contact my child's physician to obtain further explanation of the above information. This authorization is in force for the current school year unless I submit new information in writing to the school. I understand that I will be required to submit a new form each year.

Signature of Parent: _____ Contact Number: _____



Big Enough to Deliver, Small Enough to Care