CASHION PUBLIC SCHOOLS

**SEVERE FOOD ALLERGY HEALTH FORM-(NO EPIPEN)**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_ Parent/Guardian #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_ Telephone: Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor/Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital of Choice:

**NATURE OF ALLERGY/ALLERGENS**

Check all that apply: □

Peanuts​ □ Tree Nuts​ □ Milk/Dairy​ □ Eggs​ □ Wheat​ □ Seafood/Fish​ □ Soy​ □ Latex □

Student reacts to allergen by: ​

□​ Ingestion ​□​ Contact ​□​ Inhalation SYMPTOMS OF REACTION Check all that apply: □ Itching ​□​ Hives/Rash ​□​ Facial swelling ​□​ Difficulty breathing ​□​ Swelling of throat/tongue □ Swelling of lips/eyes ​□​ Difficulty swallowing ​□​ Difficulty talking ​□​ Coughing □ Abdominal pain/cramps ​□​ Nausea/vomiting ​□​ Tingling of the throat ​□​ Redness in the face □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*This form is required by the state for foods not to be given in the cafeteria