The Woods
A Montessori School

Food Allergy Action Plan

Form adapted from the VDOE approved Form

- Any changes to this Action Plan will require a new plan to be approved.
- This form must be completed in English
- One form must be completed for each food allergen. Multiple foods cannot be listed on one consent form.

Child's Name: _____ Date of Birth:_____

Child's Known Food Allergies: _____

Briefly describe how your child reacts to this allergen.

_____

_____

Please indicated what actions should be taken if your child is exposed to or discomforted by the allergen(s):

_____ No action required _____ Call 911 _____ Call Parent _____ Administer authorized medication

Is this allergy life threatening? _____ Yes _____ No

Please list below any additional actions required and indicate if allergy is life threatening:

_____

_____

I certify that the above information is accurate.

Parent or Guardian's Name (please print): _____

Parent or Guardian's Signature: _____ Date of Authorization: _____

* Please note that THE SPRINGS posts all children's allergies and dietary restrictions in the classroom as notice to all staff. By signing this form, you agree to have your child's allergy posted. If you prefer to have your child's allergy remain confidential, please notify the office.

** Please note that in order to administer medication the appropriate authorizations must be completed as required by Virginia Department of Education Service. Medication administered on an "As needed" basis requires a doctor's authorization and must be updated every six months. Please stop by the office to obtain the appropriate paperwork.

PHYSCIAN'S AUTHORIZATION

I certify that, the child listed is above has a medical allergy as described.

Additional Instructions: _____

_____

Name of Physician: _____ Phone: _____

Physician's Signature: _____ Date: _____