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**SPECIAL DIET – Children/Adults**

Medical and Religious/Cultural Food Restrictions

Child Name: Click here to enter text.

**Please list the foods that the child may not have, list suggested substitutions, and describe the allergic reaction (if applicable).**

1. **Food Allergy(ies)?** [ ] Yes [ ] No

Please check all that apply:

 [ ] wheat [ ] peanuts [ ] tree nuts [ ] milk [ ] fish [ ] eggs [ ] shellfish [ ] soy

 [ ] other (please list): Click here to enter text.

Please list recommended substitutions for foods listed above: Click here to enter text.

 Must this food(s) be avoided in all forms and/or in even small amounts?: Click here to enter text.

 Please describe the participant’s typical allergic reaction: Click here to enter text.

 ***If child does have food allergy, please complete action plan below.***

1. **Dietary Restrictions?** (including those for medical/religious/cultural or other) [ ] Yes [ ] No

If yes, what is the nature of the restriction? [ ] Medical [ ] Religious/Cultural

If yes, please list the restricted foods: Click here to enter text.

Please list substitutions for foods listed above: Click here to enter text.

Must this food be avoided in all forms and/or in even small amounts?: Click here to enter text.

Medical Professional Name (please print): Click here to enter text.

Medical Professional Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter text.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter text.

**ALLERGY ACTION PLAN**

**Allergy to:** Click here to enter text.

**Asthmatic?** [ ] Yes\* [ ] No \**Higher risk for severe reaction*

**♦ TREATMENT ♦**

**Symptoms: Give Checked Medication –**

**Provided by Parent/Guardian:**

 (To be determined by physician authorizing treatment)

If exposed to an allergen, but no symptoms [ ] Epinephrine [ ] Antihistamine

Mouth Itching, tingling or swelling of lips, tongue, mouth [ ] Epinephrine [ ] Antihistamine

Skin Hives, itchy rash, swelling or face or extremities [ ] Epinephrine [ ] Antihistamine

Gut Nausea, abdominal cramps, vomiting, diarrhea [ ] Epinephrine [ ] Antihistamine

Throat+ Tightening of throat, hoarseness, hacking cough [ ] Epinephrine [ ] Antihistamine

Lung+ Shortness of breath, repetitive coughing, wheezing [ ] Epinephrine [ ] Antihistamine

Heart+ Thready pulse, low blood pressure, fainting, pale, blueness [ ] Epinephrine [ ] Antihistamine

Other+ Click here to enter text. [ ] Epinephrine [ ] Antihistamine

If reaction is progressing (several of the above areas affected), give [ ] Epinephrine [ ] Antihistamine

The severity of symptoms can quickly change. +Potentially life-threatening

**Dosage – (medication provided by Parent/Guardian):**

**Epinephrine:** inject intramuscularly (*check one*): [ ] EpiPen® [ ] EpiPen® Jr. [ ] Twinject™ 0.3 mg [ ] Twinject™ 0.15 mg

**Antihistamine:** give (medication/dose/route): Click here to enter text.

**Other:** give (medication/dose/route): Click here to enter text.