KERRVILLE INDEPENDENT SCHOOL DISTRICT
Health Services

School Year _____-_____

FOOD ALLERGY INFORMATION

Student's name _____ Grade _____ DOB_____

Food Allergy _____

Exposure route:

_____Ingested (Allergen must be eaten)

_____Topical (Must touch allergen or surface that previously contained allergen)

_____Inhaled (The smell of the allergen can trigger a reaction)

This allergy is considered:

_____Mild

_____Moderate

_____Severe/Life threatening

Please describe what happens when your child ingests or is exposed to this food:_____

_____

_____

Treatment required (check all that apply)

_____Observation

_____Oral Medication _____ (Must be supplied by parent)

_____Epi-Pen or other Injectable medication (Must be supplied by parent)

_____Call 911

_____Other_____

_____

Parent signature _____ Date _____

Please complete this form and return to the school nurse so we may assist your child with the best care possible. In the event of accidental ingestion or contact with the allergen parents will be notified immediately.