Jackson Township Public Schools
Food Allergy Information Form

Attach student's picture here.

School:______________
School Year: 20___-20___

Student's Name:______________________________ Lunch Time / Period:__________

Teacher/Homeroom:__________________________________ Grade:__________

Parent/Guardian Contact:____

Phone Number(s):____

Severe Allergy: ____NO ____YES*

EpiPen: ____NO ____YES*
Student self-administer: ____NO ____YES

If yes, please specify:____

<u>Food Allergy</u> *(or Health-related restriction)*	**<u>Possible Reaction</u>**
1.________________________	1.________________________
2.________________________	2.________________________
3.________________________	3.________________________

- **This form must be updated annually. Food allergies and Lactose Intolerance require <u>annually updated</u> healthcare provider documentation. Please attach to this form.**

I give my permission for this form to be released to the individuals listed below.

Parent/Guardian Signature: Date:

____

Distribution:	<u>School Nurse</u>:	Form with photo and all *original* doctor's notes.
	<u>Kitchen Lead</u>:	Form with photo & *copy* of lactose intolerance note.
	<u>Principal</u>:	Form with photo
	<u>Teacher</u>:	Form with photo