Jackson Township Public Schools

Allergy Information Form

Attach Student's Picture here.

Name of 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:_____

Allergy *(or Health-related restriction)*	Possible Reaction
1._____	1._____
2._____	2._____
3._____	3._____

❖This form must be updated annually. Food allergies and Lactose Intolerance require annually updated healthcare provider documentation. Please attach to this form.

I give my permission for this form to be released to individuals listed below. In the event that the school nurse is not available, I give permission for the assigned delegates to administer epinephrine.

Parent/Guardian Signature:_____Date: _____

Distribution:		
	School Nurse:	Form with photo and all original doctor's notes
	Kitchen Lead:	Form with photo and copy of lactose intolerance note
	Principal:	Form with photo
	Teacher:	Form with photo
	Delegate:	Form with photo