Log on back →

Dietary Info from Physician

For child attending PACT Classroom

(To be completed & signed if physician has diagnosed food allergy/restriction/food additive)

Child name: _____ Class: _____ Date: _____

Food Restrictions:

List specific foods to be omitted: _____

List reactions/symptoms if child consumes foods: _____

Foods to substitute for above restriction: _____

Is **Rescue/Quick Relief Medication** (such as epi pen) needed to be kept at school? ☐ No ☐ Yes
If yes------
Name of medication _____ Dose _____
Under what symptoms to take medication: _____

Additional comments and instructions for staff at school: _____
_____

Food Additives:

List food additive: _____

Additional comments and instructions for staff at school: _____
_____

Physician Signature: _____ **date:** _____

Physician name, address, phone # _____
_____

Below to be completed by PACT teacher after plan is received from physician.

Above plan reviewed with parent on ____/_____/_____ by _____
(Teacher)

First dose of a medication may not be given at school. I (parent) verify the medication has been introduced to my child on (date) _____

Did or does child have any side effects from medication? ☐ No ☐ Yes, explain _____

Parent Signature: _____ date _____

Name and RX # of medications listed above which will need to be kept at PACT Site:

Name: _____ RX # _____ Expiration date: ____/____/_____

Staff person(s) designated to adm. Medication: _____

Where medication/additive is stored at school: _____

CBT give copies: ☐ Site Sup. to review, initial, & email to Health Coord. ____ / Copy: ☐ DCFS File / Copy: ☐ Cook
Original: ☐ Teacher for Health & Safety Notebook

LOG for quick relief medication for food allergies

Child's Name: _____ Class/Area # _____

Log below when child has symptoms and what was done. Notify parent immediately when quick relief medication is used.
(Review with parent at Parent Teacher Conferences. Parent sign and date when reviewed.)

date	time	Staff name	Describe what happened and what was done and any medication given If medication given note unusual symptoms, reactions, or changes in behavior that could be due to the medication	Date Parent review	Parent initial

_____ Complete for the year _____ _____
Teacher Signature Date

When complete for year, teacher signs off & gives to SS to place in DCFS file. SS will notify Health Coordinator by email that medication is complete and HC will take it off 3010 Report.

H – 5/22