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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.