

Physician's Signature: \_

## Food Allergy Action Plan

## Form adapted from the VDOE approved Form

\_ Date: \_

- Any changes to this Action Plan will require a new plan to be approved.
- This form must be completed in English
  One form must be completed for each food allergen. Multiple foods cannot be listed on one consent form.

Child's Name:	Date of Birth:
Child's Known Food Allergies:	
Briefly describe how your child reacts to this allergen.	
Please indicated what actions should be taken if your child is exposed to or di	scomforted by the allergen(s):
No action required Call 911 Call Parent	Administer authorized medication
Is this allergy life threatening? Yes No	
Please list below any additional actions required and indicate if allergy is life the	hreatening:
I certify that the above information is accurate.	
Parent or Guardian's Name (please print):	
Parent or Guardian's Signature:	Date of Authorization:
* Please note that THE SPRINGS posts all children's allergies and dietary rest have your child's allergy posted. If you prefer to have your child's allergy rema	trictions in the classroom as notice to all staff. By signing this form, you agree to in confidential, please notify the office.
	rations must be completed as required by Virginia Department of Education Service. ation and must be updated every six months. Please stop by the office to obtain the
PHYSCIAN'S	AUTHORIZATION
	•••••
I certify that, the child listed is above has a medical allergy as described.	
Additional Instructions:	
Name of Physician:	Phone:
Traine of Thysician.	1 110110.