Holly Area Schools

Food Sensitivities/Intolerances

Student's Name: _____ School Year: _____

Date of Birth: _____ School/Program:_____

Age: _____ Grade: _____ Teacher: _____

First Contact	Second Contact
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _____

Foods to Omit: _____

_____

What happens when student ingests food(s) listed above: _____

_____

Does student need any medications after ingesting food(s) listed: _____

_____

If student needs any medications a severe allergy medical care plan and authorization for prescription medication forms must be filled out by parent and signed by authorized medical provider.

Other information regarding diet or feeding: _____

_____

Signature of Parent: _____ Date: _____

Office Use Only:

Information shared with food service: _____ Date:_____

Signature:_____