Elkhart & St. Joseph Counties Head Start Consortium
245 North Lombardy Drive, Suite A, South Bend, IN 46619
Phone: 574-393-5864 Fax: 574-283-8108

MEDICAL STATEMENT/FOOD ALLERGY RESTRICTION PLAN

CHILD'S NAME: _____ DATE OF BIRTH: ____/_____/_____

EHS/HS SITE/ROOM NUMBER: _____

FOOD ALLERGY:	REACTION:	RECOMMENDED FOOD SUBSTITUTION:	Is medication required at school for allergy: ___ yes ___ no If yes, please include medication administration instructions:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

_____

_____

Dr. Signature: _____ Date: _____

Head Start Nurse/Consultant Signature: _____ Date: _____

Dietitian Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Teacher/TA Signature: _____ Date: _____

FACS Signature: _____ Date: _____

Consultant Notes:

_____

_____

_____

_____

_____

_____

Signature: _____Date: _____

White: Child's File Yellow: Dietitian ___Food Service Notified

Revised: 4/5/24