School Health Services

Phone: 609-584-1800 x 229

Fax: 609-584-6242

**HEALTH CARE PLAN – FOOD INTOLERANCE**

Student Name: Date of Birth:

**FOOD INTOLERANCE TO**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVENTION**

* Wash tables after art projects or eating in classroom.
* All children need to wash hands after art projects or eating in classroom.
* Students will wash their hands prior to eating.
* Students will eat only parent provided food, unless otherwise arranged with parent.

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## SYMPTOMS

Please indicate child’s known symptoms

\_\_\_ Diarrhea

\_\_\_ Vomiting

\_\_\_ Constipation

\_\_\_ Abdominal pain, cramps, nausea

\_\_\_ Flatulence (passing gas)

\_\_\_ Loss of Appetite

\_\_\_ Weight loss or Failure to gain weight

\_\_\_ Short stature, not growing in height

\_\_\_ Protruding abdomen

\_\_\_ Muscles wasting away

\_\_\_ Teeth staining, prone to dental decay

\_\_\_ Hair loss, lack of hair growth

\_\_\_ Lethargic / Low Energy

\_\_\_ Depression

## ACCIDENTAL EXPOSURE

* Refer to school Nurse
* Notify Parent/Guardian
* Monitor Symptoms

\_\_\_ Irritability

\_\_\_ Behavior changes

\_\_\_ Seizures

Student has related autoimmune disease:

\_\_\_ Insulin-Dependent Diabetes

\_\_\_ Thyroid Disease

\_\_\_ Arthritis

\_\_\_ Eczema

\_\_\_ Asthmas

\_\_\_ EOS

\_\_\_ Other – Specify:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Physician Print Physician’s Name Date