



Medical -Allergies / Food Allergies

Child's name: _____

Food Allergy: _____

Reaction: _____

All medical-allergies/concerns require a physician statement that describes the allergy/concern as well as any prescribed actions (physician approved allergy action plan) as determined with your provider.

This form must be updated each time a change occurs with your child's diet. All food allergies require a physician statement that describes the allergy as well as the prescribed actions as determined with your provider. If any of your child's allergies are life threatening and/or require an epi-pen prescription, all food to be consumed by your child while attending VCELS will be supplied by parent/guardian.

Families of children with allergies need to check the menu to see what item(s) should be provided by parent as a food supplement or replacement for a well balanced meal. VCELS uses USDA guidelines to determine a well balanced meal.

Lunch: One serving of protein, Two servings of fruit or vegetables,
One serving of grain and One serving of milk or milk equivalent.

AM/PM Snack: At least 2 of the following- Milk or equivalent, Fruit (or juice) or Vegetable, Protein, Grain.

The replacement item(s) must be provided on a daily basis, and not require preparation, refrigeration or storage at VCELS or by VCELS Staff. The replacement item(s) need to be clearly marked with what it is replacing. Provide only enough for one meal as extras will be disposed of after the meal has ended. Unmarked items will not be served. If adequate supplements are not provided, VCELS staff will document the occurrence and help you determine a solution to assure your child receives a well balanced diet at school.

Medical-Allergies/Concerns: _____

Parent/Guardian Signature: _____ **Date:** _____

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Office Use Only (Before enrollment can occur):

Office Manager \_\_\_\_\_ Date \_\_\_\_\_

☐ Physician Note returned ☐ Classroom posting prepared

Lead Teacher \_\_\_\_\_ Date \_\_\_\_\_

☐ Parent Intake Meeting ☐ Informed classroom staff ☐ Information posted

Director \_\_\_\_\_ Date \_\_\_\_\_

Notes:

☐ Dietary Restrictions Policy Waiver (signed)