FOOD ALLERGY FORM FOR CAFETERIA
MUST BE COMPLETED BY A DOCTOR EACH SCHOOL YEAR

Exhibit 6.3. Medical Statement for Non-Disabled Child

Mississippi Department of Education
Office of Child Nutrition
Medical Statement for Non-Disabled Child

Part I (to be completed by School District/School/Organization/Sponsor)
Date_____

Name of School District/School/Organization/Sponsor_____

Name of Student/Individual _____

Address_____

_____Date of Birth_____

School/Provider/Center Name_____

School/Provider/Center Address_____

Part II (to be completed by a Medical Authority)

Patient's Name_____Age_____

Diagnosis_____

_____

Describe the medical or other special dietary needs that restrict the child's diet_____

_____

_____

If yes, list food(s) to be omitted from diet and food(s) that may be substituted_____

_____

_____

Special equipment needed_____

_____

_____

_____ _____
Date Signature of Medical Authority

**IF THE CHILD HAS AN EPI-PEN DUE TO FOOD ALLERGY, PLEASE FILL OUT ATTACHED COPY.

Winona-Montgomery Consolidated School District

For any student with an Epi Pen

American Academy of Allergy Asthma & Immunology

For any student with an Epi Pen

Anaphylaxis Emergency Action Plan

Patient Name: _____ Age: _____

Allergies: _____

Asthma ☐ Yes *(high risk for severe reaction)* ☐ No

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis	
MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
   - ☐ Adrenaclick (0.15 mg)
   - ☐ Adrenaclick (0.3 mg)
   - ☐ Auvi-Q (0.15 mg)
   - ☐ Auvi-Q (0.3 mg)
   - ☐ EpiPen Jr (0.15 mg)
   - ☐ EpiPen (0.3 mg)
   - Epinephrine Injection, USP Auto-injector- authorized generic
     - ☐ (0.15 mg)
     - ☐ (0.3 mg)
   - ☐ Other (0.15 mg)
   - ☐ Other (0.3 mg)

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ work_____ cell_____

   Emergency contact #2: home_____ work_____ cell_____

   Emergency contact #3: home_____ work_____ cell_____

Comments: _____

_____

_____

Doctor's Signature/Date/Phone Number

_____

Parent's Signature (for individuals under age 18 yrs)/Date

4/2017