**Food Allergy/Intolerance Notification Form**

This form should be completed by the parent or guardian of pupils under the age of 18 (By signing this form, you confirm you are providing accurate information that is true to the best of your knowledge)

Name of Pupil…………………………………………………………………………

Class……………………………………………………………………………………….

Teacher………………………………………………………………………………….

Date………………………………………………………………………………………

(This information will be reviewed at the start of every year. Please notify us of any changes.)

Does your child have an allergy or intolerance to any of the following allergens?

 Yes Please tick the relevant box or boxes below

 Peanuts Celery Cereals (Gluten)

 Milk Sesame Soya

 Nuts Molluscs Mustard

 Eggs Crustaceans Sulphites



 Fish Lupin Dairy

Other (Please State): ……………………………………………………

When were you first aware your child has an allergy/intolerance? ........................................................

When did your child last react to the allergen? .......................................................................................

What symptoms were present? ..............................................................................................................

……………………………………………………………………………………………………………………………………………………………

What treatment was given? ....................................................................................................................

How long did the reaction last? ...............................................................................................................

Were paramedics involved? ....................................................................................................................

Did the child attend hospital? ..................................................................................................................

Was the food allergen actually eaten? ....................................................................................................

What kind of food (e.g. a type of fish) was involved? ..............................................................................

Was it an ingredient of the food? ............................................................................................................

Was it as a result of cross contamination? ..............................................................................................

Was it as a result of coming into close contact with others who have eaten or come into contact with the allergen?

………………………………………………………………………………………………………………………………………………………......

Has this allergy/intolerance been medically diagnosed? Yes No

If not, are they awaiting diagnosis? Yes □ No □

Date of diagnosis………………………………………………… Hospital……………………………………………………………….

Medical evidence provided? Yes No Attached? Yes No

Does your child require medication? Yes No

Which medication? ..................................................................................................................................

How is it administered? ...........................................................................................................................

Does it have a Use By date? .....................................................................................................................

I confirm that the information supplied within this document is correct. Any changes in my child’s allergy/intolerance status will immediately be notified to the school.

Name of Parent/Guardian completing this form………………………………………………………………………………….

Address……………………………………………………………………………………………………………………………………………….

Contact Telephone Number…………………………………………………………………………………………………………………

For office use only

…………………………………………………………………………………………………………………………………………………………….

Review Date: ………………………………… Any changes - Yes □ (complete new form) No □

Review Date: ………………………………… Any changes - Yes □ (complete new form) No □