SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Parent Information Packet: MILK Allergy/Sensitivity/Intolerance Documentation Requested

To the parent of ______________________________________ Date: _________________________

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have a MILK allergy/sensitivity/intolerance to MILK.

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special medical diet, food substitution, and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

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School Health Staff

If this is not a health concern for your child, please check the box below, sign the bottom of this page and return to the school nurse.

____ This is not a health concern.

____ My child has an allergy/sensitivity/intolerance to MILK and does not drink milk, but is able to eat foods that contain milk/dairy.

____ My child has an allergy/sensitivity/intolerance to MILK and can NOT eat foods containing milk or dairy products. I understand that my student must have a **Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet** Form on file with the School Health Office in order for the cafeteria to accommodate special dietary needs other than Milk Substitution.
PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:

- ☑ **Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet** form signed by an **Arizona Licensed Physician/Health Care Provider** (provide once and update as needed). If this form is NOT submitted to the School Health Office, then the cafeteria can NOT make accommodations for your child.
- ☑ **Food Allergies Medical Management Plan for School** Form signed by an **Arizona Licensed Physician/Health Care Provider:** If student requires and Epi-Pen
- ☑ **Please see school health staff if your child requires medications to be given at school.**

_________________________________ _________________________________ _________________________________

Name of Parent and/or Guardian Signature Date