

**Special Preparation
and Food Allergy Plan**
Supplemental Form



taking on disability together

Participant Name: _____ **Date:** _____

A. Special Food Preparation

Indicate texture of food needed:

- Regular Chopped Mechanical Soft Pureed

Indicate thickness of liquids needed (thickening agent must be provided by family):

- Regular Nectar Honey Pudding

B. Food Allergies

What food(s) is the participant allergic to?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Milk/Dairy | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Dyes or coloring
Please specify: _____ | <input type="checkbox"/> Other: _____ |

What type of contact induces an allergic reaction?

- | | |
|---|---|
| <input type="checkbox"/> Ingesting the allergen | <input type="checkbox"/> Eating near others with the allergen |
| <input type="checkbox"/> Ingesting food with the allergen | <input type="checkbox"/> Any exposure |
| <input type="checkbox"/> Other: _____ | |

What signs will we see if the participant is having experiencing an allergic reaction?

- | | |
|---|---|
| <input type="checkbox"/> Skin rash/hives | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Upset stomach/bowels | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Swelling of lips | <input type="checkbox"/> Swelling in tongue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drop in blood pressure |
| <input type="checkbox"/> Closed throat | <input type="checkbox"/> Other: _____ |

If experiencing an allergic reaction, will we see signs/symptom immediately or is there a delayed response? _____

Please number the procedures below in order of desired emergency care:

_____ Call parent/guardian immediately participant is showing signs/symptoms of an allergic reaction.

_____ Call 911 if signs/symptoms of an allergic reaction appear.

- Under what circumstances should staff contact 911? _____

_____ Administer emergency medication (Epi-pen, inhaler, Benadryl).

- Under what circumstances should staff administer emergency medication? _____

- Can the participant self-administer the emergency medication? yes no

Directions: Please complete the table below with a list of safe snacks and unsafe snacks for the participant. We cannot guarantee that safe snacks will be provided during respite events, so if your loved one has an allergy please be prepared to send them with a snack to the event so that they can enjoy in snack time with their peers.

Safe Snacks	Unsafe Snacks

C. General Information

Can the participant identify foods that are safe to eat? yes no

Can the participant inform an adult if they are having an allergic reaction? yes no

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

Parent Signature

Date

For staff use only:

This form was received and reviewed by:

Name / Title

Date