Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID 83854
PO Box 40, Post Falls, ID 83877
(208) 773-6976

Dietary Restriction Information

Dear Parent/Guardian:

If your child has a food sensitivity, intolerance or dietary preferences, please complete this form and return it to your child's school.

Student's Name: ____
School: ______________________________ Grade: ____________ Teacher: ________________________________
Parent/Guardian: ____Phone: ____________________
Physician's Name: ____ Phone: ____________________

1. Please list all of your child's dietary restrictions and indicate if sensitivity, intolerance or preference: ______________
____
____

2. Check the type of reaction your child has had in the past:
☐ Abdominal Discomfort ☐ Diarrhea ☐ Bloating/Flatulence ☐ Nausea/Vomiting ☐ Heartburn ☐ Headaches
☐ Other: ____

3. Does your child take medication for related to food sensitivity/intolerance? ☐ Yes ☐ No ☐ Not currently

Please list all medications for or to prevent a reaction, prescribed or over the counter:

Medications	Dose/Time	Side Effects

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

*An **Authorization for Medication Administration** form will need to be completed. *

4. There is a **Meal Accommodation** form for food services, if needed.

5. If the school nurse has more questions regarding this form what is your preferred method of contact?
☐ Phone or ☐ Email: ____

Parent/Guardian's signature: ____ Date: _______________

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

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