GUIDELINES FOR MANAGING LIFE-THREATENING FOOD ALLERGIES

PARENT PACKET

VENUS ISD

Parent Packet-Allergy

Dear Parent:

You have informed us that your student has an allergy. Enclosed are forms, which we need to be completed and returned to the School Nurse. This information will help us determine how to help keep your child safe during the school day.

Please send a current picture of your child in order for the student to be easily identified. This information will be distributed to appropriate personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your child daily. We also need medical documentation, special instructions and medications as directed by a physician.

To help your child please let us know of any changes in your child's medical condition or emergency contact numbers.

The following need to be returned to the School Nurse.

- Allergy Healthcare Plan
- Food Allergy Assessment Form
- Life-Threatening Allergy Care Plan (just sign, and physician will need to fill out.)
- Food Service Modifications
- Authorization for Exchange of Medical Information We are looking forward to a great

year with your child!

ALLERGY HEALTHCARE PLAN

School Year:

ALLERGENS:

(This form will be made available to teachers and appropriate school staff.)

Student's Name: _____ DOB: ____ / ____ / ____

School: _____ Teacher: _____ Grade: _____

Place Student's Picture Here

Parent/Guardian(s) Name(s): _____

Address/Zip Code:

Allergist/Doctor: _____ Phone # _____

Hospital of Choice: _____

Parent/Guardian 1 : — Home: _____ Work _____ Cell: _____

Parent/Guardian 2 : — Home; _____ Work _____ Cell: _____

Or call Emergency Contact if unable to reach Parent/Guardian:

Name: _____ Phone: _____ Relation: _____

---

1 . Date of student's last allergic episode?____ / ____ / ____ Never had an allergic episode What happened?

_____

2. Diagnosed by skin/blood testing? ayes No Date ____ / ____ / ____ Physicians Name:

_____

3. Has student ever been hospitalized for an allergic episode? Yesa NO a Date / ____ / ____

4. Does your child react when they eat the above allergen? ayes a No
Type of reaction: Stomachache a Itching Hives ☐ Itchy throat
a Cough/Wheezing Anxiety/Restlessness a Swollen lips or tongue
Other

_____

5. If this is a food allergy, will you be sending lunch? ayes ONO

6. Does your child react when they touch (or are bitten/stung if Insect) the above allergen? ayes DNo
Type of reaction: Rash Itching a Hives a Itchy throat CoughTWheezing
☐ Anxiety/Restlessness Swollen lips or tongue a Other

_____

7. Does your child react when they smell or inhale the above allergen? a Yes DNO
Type of reaction: Stomachache Itching Hives ☐ Itchy throat

DCoughÑVheezing Anxiety/Restlessness ☐ Swollen lips or tongue
Other

8. Can your child sit near someone eating the allergen? ayes ONO
9. Does your child know what the allergen looks like and how to avoid it? ☐Yes a No

ALLERGENS:

10. What do you do at home (accommodations, diet restrictions, substitutions)?
11. Can your child eat things processed in a facility that also processes the allergen? ayes DNC)
12. Can the school send a letter home notifying the classroom about your child's allergy in order to decrease the chances the allergen will be brought to school by a classmate? ayes ÜNO
13. List the Medication(s) your student takes for allergic reactions (please fill out the attached Medication Authorization Form if needed) *

Name of Medication:	Dosage:	Time of Day:

14. Additional comments:

Food Allergy Assessment Form

Student Name: Date of Birth: Date:

Parent/Guardian: Phone: Cell/work:

Health Care Provider (name) treating food allergy: Phone:

Do you think your child's food allergy may be life-threatening? a No ayes (If YES, please see the school nurse as soon as possible).

Did your student's health care provider tell you the food allergy may be life-threatening? a No ayes (If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

a Peanuts ❑ Fish/shellfish a Eggs a Peanut or nut butter a Soy products a Milk a Peanut or nut oils ❑ Tree nuts (walnuts, almonds, pecans, etc.) Please list any others:

How many times has your student had a reaction? a Never Once a More than once, explain:

When was the last reaction?

Are the food allergy reactions: a staying the same a getting worse a getting better

Triqqers and Symptoms

What has to happen for your student to react to the problem food(s)? (Check all that apply)

Eating foods O Touching foods a Smelling foods a Other, please explain:

What are the signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say.)

How quickly do the signs and symptoms appear after exposure to the food(s)?

SecondsMinutesHoursDays

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

a No a Yes, explain:

Does your student understand how to avoid foods that cause allergic reactions? a Yes No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? a No Yes

Does your student know how to use the treatment? ONO a Yes

Please describe any side effects or problems your child had in using the suggested treatment:

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

a Yes.

❑ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

a Yes.

a No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

❑ Yes.

a No, I need to get the medication/treatment and bring it to schooL

What do you want us to do at school to help your student avoid problem foods?

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

a Yes.

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

Adapted with permission from ESD 171 SNC Program

LIFE-THREATENING ALLERGY CARE PLAN

NAME:			Severe ALLERGY to: Other Allergies:	Place student picture here
Please list the specific symptoms the student has experienced in the past:			Asthma? Yes (High risk for severe reaction) No	
School:	Date of Birth:	Grade:	Routine medications (at homefschool):	
Bus #	Car	Walk	Date of last reaction:	
Location(s) where Epipen@/Rescue medications is/are stored: Office Backpack On Person Coach Other _____				

Allergy Symptoms:	Ifyou severe allergic reaction, immediately ADMINISTER Epinephrine and call 911
MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students ma ex erience s m toms other than those listed above

MEDICATION ORDERS

EpiPen@ (0.3)		EpiPen Jr.@ (0.15)			Side Effects:
Repeat dose of EpiPen@:		Yes	No		If YES, when
Antihistamine:	_____cc/mg				Give: Teaspoons Tablets by mouth Side Effects:

- It is medically necessary for this student to cany an Epipen@during school hours. Yes No
- Student may self-administer Epipen@. C] Yes No
- Student has demonstrated use to LHCP. Yes No

Licensed Health Care Provider's Signature:	Date:
Licensed Health Care Provider's Printed Name:	Phone: Fax Number:

ACTION PLAN

GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.

- NOTE TIME_____ AMIPM (Epipen@/adrenaline given) • NOTE TIME _____AM/PM (Antihistamine given)
  > CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epipen@ is administered.
- DO NOT HESITATE to administer Epipen@ and to call 911 even if the parents cannot be reached.
- Advise 91 1 student is having a severe allergic reaction and Epipen@ is being administered.
- An adult trained in CPR is to stay with student—monitor and begin CPR if necessary.

Call the School Nurse or Health Services Main Office at_____.

- Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
- Notify the administrator and parent/guardian.
- Dispose ofused EpiPenØ in "sharps" container or give to EMS along with a copy of the Care Plan.

Individual Considerations

Bus —Transportation should be alerted to student's allergy.

- This student carries Epipen@ on the bus: Yes NO

- Epipen@ can be found in: Backpack Waistpack On Person Other (specim

- Student will sit at front of the bus: Yes ◆ Other (specify):

Field Trip Procedures — Epipen@ should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: Yes No
- Staff members on trip must be trained regarding Epipen@use and student health care plan (plan must be taken).
- Other (specify)

CLASSROOM -For Food allergy only

- Student is allowed to eat only the following foods:

Those in

☐ manufacturer's packaging with ingredients listed and determined allergen-safe by the nurse/parent or
☐ Those approved by parent.
☐ Middle school or high school student will be making his/her own decision.
☐ Alternative snacks witl be provided by parent/guardian to be kept in the classroom.
☐ Parent/guardian should be advised of any planned parties as early as possible.

[2 Classroom projects should be reviewed by thc tcaching staff to avoid specified allergens.

- Student should havc someone accompany him/her in the hallways. Yes No
- Other (specify):

CAFETERIA ☐ NO Restrictions

Student will sit at a specified allergy table.
Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following student's departure.
Student witl sit at the classroom table at a specified location.

- Cafeteria manager and hostess should be alerted to the student's allergy.
- Other:

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:
4.	Relationship:	Phone:

◆ I request this medication to be given as ordered by the licensed health care provider.

◆
I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).

◆ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.

◆ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.

I request and authorize my child to carry and/or self-administer their medication. Yes No

This permission to possess and self-administer an EpiPen@ may be revoked by the principal/schoot nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature Date

Student demonstrated to the nurse the skill necessao' to use the medication and any device necessary to self-administer the medication. Device(s) if any, used:_____ Expiration date(s): _____
School Nurse Signature Date

A copy of the Health Care Plan will be kept in the substitute folder and given to ali star members who are involved with the student.

Adapted with permission from Riverside School District

Fi ure 1. Eatin and Feedin | Evaluation: Children with S ecial Dieta | Needs

PART A			
Student's Name			Age
Name of School	Grade Level	Classroom	
Does the Child have a Disability? If Yes, describe the major life activities affected by the disability.		Yes C]	No
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes	No
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, com lete Part B of this form and have it si nedb a reco nized medical authori		Yes	No
If the child does not require special meals, the parent can sign at the bottom of this form and return the form to the school food service.			
PART B			
List any dietary restrictions or special diet.			
List any allergies or food intolerances to avoid.			
List foods to be substituted.			
List foods that need the fotlowing change in texture. If all foods need to be prepared in this manner, indicate "All". Cut up of chopped into bite size pieces: Finely ground: Pureed or Blended:			
List any special equipment or utensils that are needed.			
Indicate any other comments about the child's eating for feeding patterns.			
Parent's Signature		Date:	
Physician or Medical Authority's Signature:		Date:	

Accommodating Children with
Special Dietary Needs 13.34

Texas Department ofAgrtczdture .Vovember 2011

Authorization for Exchange of Medical Information

SECTION I - INFORMATION REQUESTED FROM

NAME:	NAME OF PERSON DISCLOSING INFORMATION:
AGENCY:	
ADDRESS:	TITLE:
Name of Student:	Birth Date: Date:
Specific nature of information to be disclosed:	
SECTION II - UTHORIZATION	
I hereby authorize the release of medical information described with the school/agency indicated in Section III.	
This authorization expires on:	in Section I to the individuals who are affiliated
Parent Signature	Date
Student Signature	Date
If the student is a minor authorized to consent to health care student shall sign this authorization form.	hout parental consent under federal and state law, only the
SECTION III - AGENCY ECEIVING INFORMATION	
AGENCY/SCHOOL:	This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any

NAME/POSITION (Nurse, Administrator, etc.)	agency or person not listed on this form without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.
ADDRESS:	See chapter 70.02 RCW. Envelope shall be marked "CONFIDENTIAL".

 Parents responsibilities:

- Inform the school nurse of your child's allergies prior to the start of school or as soon as possible after diagnosis. Provide a list of products and/or ingredients to avoid.
- Fill out and return all forms sent home.
- Attach a current photograph to the forms sent to you.
- Provide the school nurse with health information from your child's physician.
- Provide the school nurse with written permission to communicate with your child's physician. (Authorization for Exchange of Medical Information form).
- Provide the school nurse annual updates of your child's allergy status.
- Participate in developing an Individualized Health Care Plan with the school nurse and school team.
- Educate your child on the self-management of their allergy including: Safe and unsafe products
- Strategies for avoiding exposure to allergen, such as not trading food with other students, only eating food that has been identified safe. Symptoms of an allergic reaction
- How to read food labels
- Provide emergency contact information and update the information as changes occur.
- Provide the school with at least one or two up-to-date epinephrine auto-injectors,
- Consider providing a medical alert bracelet for your child.
- You may provide a non-perishable lunch to be kept at school in case your child forgets to bring lunch one day.
- Provide a bag of "Safe Snacks" in your child's classroom so there is always something your child can choose from during an unplanned special event.
- Consider volunteering as chaperone on your child's field trips.
- Be available to determine if a food is safe for your child to eat.
- Contact the Food Service Director, Tina McCormick, for questions regarding the lunch program at 972-366-3748 ext. 310.

Venus Elementary School

Allergy Management Plan

Students Responsibilities:

- Should not trade or share food with anyone.
- Should not eat anything with unknown ingredients or known to contain allergen if has food allergy.
- Should notify an adult immediately if they eat something they believe may contain the food to which they are allergic.
- Wash hands before and after eating.
- Learn to recognize symptoms of an allergic reaction.
- Should be proactive in the care and management of their allergies and reactions based on their developmental level.
- Wear medical alert bracelet.
- Read food lables.
- Report any instances of teasing or bullying to an adult immediately.

The ultimate goal is that our children eventually learn to keep themselves safe by making good choices and advocating for themselves.

Venus Elementary School

Allergy Management Plan

School Nurse Responsibilities:

- Prior to entry into school or immediately after diagnosis ensure allergy packet received from parent.
- Notify all staff who come in contact with the student with allergies-including principal, teachers, specialists, PE teacher, aids, food service personnel, bus driver, etc.
- Participate in annual training and education for faculty and staff regarding lifethreatening allergies. Designated staff will have in depth training on how to recognize symptoms of anaphylaxis and when and how to administer an EpiPen.
- Will communicate with parents on a regular basis.
- Will meet with the student's parents to develop a written Individual Health Care Plan/Emergency Care Plan
- Will make sure all necessary Health Plans, and Doctors orders are signed by the parent and physician.
- Request that the parent obtain and provide to the school the medications ordered by the physician to treat an allergic reaction.
- Ensure that the child with life-threatening allergies is assigned to staff that are trained in recognizing signs and symptoms of life-threatening allergic reactions, trained to use an epinephrine auto-injector, and trained in emergency procedures during off campus functions.
- Instruct the student to notify a teacher or any appropriate adult if they believe they ingested a food product that may contain something that they are allergic to, or if they fill ill after eating.

Venus Elementary School

Allergy Management Plan

- Will keep epinephrine auto-injectors in an easily accessible place in the Nurse's office. A copy of the student's Emergency Care Plan will be attached to the student's EpiPen. Trained staff will know where emergency medicine is kept.