**Food Allergy Action Plan**

*Emergency Care Plan*

Name: ___________________________  D.O.B.: ___ / ___

Allergy to: ____________________________

Weight: _______ lbs.  Asthma:  □ Yes (higher risk for a severe reaction)  □ No

**Extremely reactive to the following foods:**

**THEREFORE:**

□ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

□ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion:**

**One or more** of the following:

**LUNG:**  Short of breath, wheeze, repetitive cough

**HEART:**  Pale, blue, faint, weak pulse, dizzy, confused

**THROAT:**  Tight, hoarse, trouble breathing/swallowing

**MOUTH:**  Obstructive swelling (tongue and/or lips)

**SKIN:**  Many hives over body

Or **combination** of symptoms from different body areas:

**SKIN:**  Hives, itchy rashes, swelling (e.g., eyes, lips)

**GUT:**  Vomiting, diarrhea, crampy pain

**MILD SYMPTOMS ONLY:**

**MOUTH:**  Itchy mouth

**SKIN:**  A few hives around mouth/face, mild itch

**GUT:**  Mild nausea/discomfort

**Medications/Doses**

Epinephrine (brand and dose): ____________________________

Antihistamine (brand and dose): ____________________________

Other (e.g., inhaler-bronchodilator if asthmatic): ____________________________

**Monitoring**

*Stay with student; alert healthcare professionals and parent.*  Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature  Date  Physician/Healthcare Provider Signature  Date

TURN FORM OVER  Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011
EPI-PEN Auto-Injector and EPI-PEN Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap
- Hold orange tip near outer thigh (always apply to thigh)
- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
- Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

- Remove GREY caps labeled "1" and "2."
- Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: _____) Doctor: _____________________________
Parent/Guardian: _____________________________ Phone: (___) _______ 

Other Emergency Contacts

Name/Relationship: _____________________________ Phone: (___) _______
Name/Relationship: _____________________________ Phone: (___) _______
Charter School of Excellence
Authorization for Medication to be taken during School Hours

I request that my child: ______________________, Date of Birth ___________, Grade _____, be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the medication policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dose.

I agree to waive the School District, their officers, representatives and employees of liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risk of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claims for acts of negligence by employees of the School District.

Furthermore, as a parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Charter School of Excellence, officers, and their employees against loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray the damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursement or indemnification.

Name of medication to be given at school: __________________________________________

Other medications student is taking: __________________________________________________________________________

Allergies: ______________________________________________________________________________________________________

_________________________________________________________ Date ____________________________
Parent/Guardian Signature Emergency Contact

The Physician Completes the Following Section:

Name of medication to be given at school: __________________________________________

Diagnosis for which the medication is given: _________________________________________________________________________

Dosage: _______________ Time(s): _______________ Route: __________________________________________________________________

Significant side effects: _____________________________________________________________________________________________

Dates Medication to be given from: _______________ to __________________________________________

Can this medication be adjusted to accommodate class schedule: yes or no
If yes, by how much time? ______________________________________________________________________

Other information: _________________________________________________________________________________________________

________________________________________ Printed Physician Name ____________________________
Physician Phone Number and Fax Number

________________________________________ 5/2010
Physician Signature
# Medical Plan of Care for School Food Service

(Students with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs. USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose disability restricts their diet and is supported by a statement signed by a licensed physician. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."

- The school may choose to accommodate a student with a non-disabling special dietary need that is supported by a statement signed by a recognized medical authority (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a non-disabling special dietary need, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or recognized medical authority (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

## Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
<th>Gender (M/F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School/Center/Program</td>
<td>Grade Level/Classroom</td>
<td></td>
</tr>
<tr>
<td>Parent's/Guardian's Name</td>
<td>Address, City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
<td></td>
</tr>
</tbody>
</table>

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## Part 2: Request for milk substitution for non-disabling special dietary needs only

- [ ] School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.

- [ ] School/school district provides ___________ as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk?  
- Yes [ ] No [ ]

List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

Medical Authority or Parent/Guardian Signature: ____________________________ Date: ____________

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## Part 3: To be completed by Physician/Medical Authority

**Disability/Special Dietary Needs**

Does the child have a disability?  
- Yes [ ] No [ ]

If Yes,  
Please describe the major life activities affected by the disability.

Does the child's disability affect their nutritional or feeding needs?  
- Yes [ ] No [ ]

If the child does **not** have a disability*, does the child have special nutritional or feeding needs?  
- Yes [ ] No [ ]

*(These accommodations are optional for schools to make)*

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

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## Part 4: To be completed by Physician/Medical Authority

**Diet Order**

List any dietary restrictions, such as food allergies, intolerances or restrictions:

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Special Dietary Needs:  

January 2010
List specific foods to be substituted (Substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."
Cut up/chopped into bite sized pieces:
Finely Ground:
Pureed:
List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number
Office Stamp
Physician/Medical Authority's Signature
Date

Part 5: Parent Signature

Part 6: School Nutrition Program Signature

Health Insurance Portability and Accountability Act Waiver
In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize ______________________ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to ______________________ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on ________________ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: ______________________

(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ______ Date ______ ______ Date ______ ______ Date ______ ______ Date ______ ______ Date ______ ______ Date ______

A copy of this form should be kept by the School Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.

Special Dietary Needs

January 2010