

Dear Parents,

We are required to have the attached form on file in the school district on any child who has a food allergy or any dietary restrictions. Please fill out, have your doctor sign and return to school as soon as possible.

Thank You,

Health Room Staff
Kearney R-1 School District

Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
Telephone:	

For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

Diet Prescription (check all that apply):

- Diabetic (include calorie level or attach meal plan)
 Modified Texture and/or Liquids
 Reduced Calorie
 Food Allergy (describe): _____
 Increased Calorie
 Other (describe): _____

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS

SUBSTITUTIONS

Indicate Texture:

- Regular
 Chopped
 Ground
 Pureed

Indicate thickness of liquids:

- Regular
 Nectar
 Honey
 Pudding

Special Feeding Equipment

Additional comments:

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature

Telephone Number

Date

Signature of Preparer or Other Contact

Telephone Number

Date

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian

Date

Dear Parent / Guardian,

Please be aware of the **School District Food Allergy Guidelines** applicable for food brought into/or shared with the classroom. The guidelines outline specific requirements that must be complied with in order for food to be brought into the classroom. The guidelines provide clear and concise procedures in this area, and all faculty and administration are aware of these guidelines. However, it must be pointed out that while they are specific, the guidelines in and of themselves, are merely guidelines. In other words, a situation can still occur where a non-compliant food item may enter the classroom and not be detected. While we hope this does not happen, we must still remain aware that it can. For this reason, we feel it necessary to make you aware of this possibility and advise that if you still have concerns in this area you may want to provide your own child's snacks / treats for parties and other social events. Feel free to discuss your concerns and options with your child's teacher and/or health room staff.

Also with this plan we will encourage designated seating in the cafeteria for our severe food allergy students. This area will be considered a "safe zone". Other classmates may sit in this area provided they are not consuming any allergen of concern. The most common severe allergy of our students is to nut products. Students having a school-prepared hot lunch are considered "safe", as OPAA does not serve foods prepared with nuts or nut products. Our "safe zone" requires a specific cleaning protocol to avoid cross contamination, which is another step in providing safety. Due to the above we feel it is necessary to encourage the "safe zone" area for our severe allergy students.

- I have read the above and wish to have my child sit in the "safe zone" area with designated classmates.
- I have read the above and choose NOT to have my child sit in the "safe zone" area. I understand that by doing so, the risk that my child may be exposed to an allergen may be increased.

Child Name: _____

Parent Signature: _____

Date: _____

Food Allergy Action Plan

Emergency Care Plan

Place
Student's
Picture
Here

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



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

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

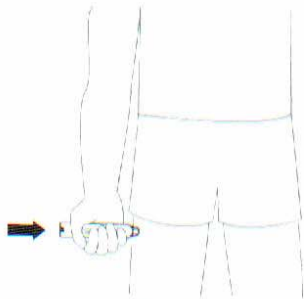
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN 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

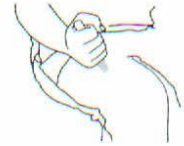


DLY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharmé, L.P.

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: () - _____

Phone: () - _____

Other Emergency Contacts

Name/Relationship: _____

Name/Relationship: _____

Phone: () - _____

Phone: () - _____