FOOD ALLERGY PACKET

DEFINITIONS

In accordance with state guidelines, and for the purposes of these procedures, the following definitions apply:

FOOD INTOLERANCE	An unpleasant reaction to a food that, unlike a food allergy, does not involve an immune system response or the release of histamine. Food intolerance is not life-threatening.
ALLERGIC REACTION	An immune-mediated reaction to a protein. Allergic reactions are not normally harmful.
SEVERE FOOD ALLERGY	An allergy that might cause an anaphylactic reaction.
ANAPHYLACTIC REACTION	A serious allergic reaction that is rapid in onset and may cause death.
FOOD ALLERGY MANAGEMENT PLAN (FAMP)	A plan developed and implemented by the District that includes general procedures to limit the risk posed to students with food allergies and specific procedures to address the care of students with a diagnosed food allergy who are at risk for anaphylaxis.
EMERGENCY FOOD ALLERGY ACTION PLAN (EFAAP)	A personalized plan written by a health-care provider specifying the delivery of accommodations and services needed by a student with a food allergy and actions to be taken in the event of an allergic reaction.
INDIVIDUALIZED HEALTH-CARE PLAN (IHP)	A plan written by a school nurse based on orders written by a health-care provider that details accommodations or nursing services to be provided to a student because of the student's medical condition.

Exhibit A: Request for Food Allergy Information {pink} (New-to-District Students Only)

Exhibit B: Severe Food Allergy Packet (Consists of Item 1: Statement Regarding Meal Substitutions or Modifications; Item 2: EFAAP; Item 3: Medication Administration Authorization Form; Item 4: CISD Health Services Medication Administration Rules)

Exhibit C: Notice of Student with a Diagnosed Severe Food Allergy (for Substitutes – Completed by Campus Principal)Exhibit D:Notice of Student with a Diagnosed Severe Food Allergy (for Others – Completed by Campus Principal)

Exhibit E: Anaphylaxis Incident Report Form

Exhibit F: Individualized Health-care Plan (2 pgs)

REQUEST FOR FOOD ALLERGY INFORMATION

(The District must request, at the time of enrollment, that the parent or guardian of each student attending the District disclose the student's food allergies. This form will satisfy this requirement. Additional information regarding food allergies, including maintaining records related to a student's food allergies, can be found at FD and FL.)

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the District in order to enable the District to take necessary precautions for your child's safety.

"Severe food allergy" means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion, or skin contact that requires immediate medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's allergic reaction to the food.

Food	**Intolerance***	**Severe anaphylactic allergy which could result in death**

* If the food sensitivity is an intolerance, this form will be used as a reminder to your child in the event he/she chooses this particular food item.

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Educational Rights and Privacy Act and District policy. [See FL]

Student name: _____ Date of birth: _____Grade: _____

Parent/Guardian name: _____

Work phone: _____ Home phone: _____

Parent/Guardian Signature: _____ Date: _____

Date form was received by the school: _____

REGISTRAR, please send copies of this completed form to *Aramark/Food Service* and the campus *Nurse*

(Print this form on light **PINK** paper)

SEVERE FOOD ALLERGY PACKET

LETTER REQUESTING ADDITIONAL DOCUMENTATION FOR STUDENT IDENTIFIED AS HAVING A SEVERE FOOD ALLERGY

Dear Parent:

You have disclosed that your child has a severe food allergy. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. **Please complete the forms attached to this letter as part of the Severe Food Allergy Packet**:

- ☐ Statement Regarding Meal Substitutions or Modifications (Item 1)
- ☐ Emergency Food Allergy Action Plan (EFAAP) 2 Pages (Item 2)
- ☐ Medication Administration Authorization Form (Item 3)
- ☐ Crowley Independent School District Health Services Medication Administration Rules (Item 4)

Please have your physician or other licensed health-care provider complete these forms and return them to the office as soon as possible.

Sincerely,

_____

(Principal, Campus Nurse Pod Leader, District Food Allergy Coordinator)

STATEMENT REGARDING MEAL SUBSTITUTIONS OR MODIFICATIONS

The United States Department of Agriculture regulations require substitutions or modifications in school meals for children whose disabilities restrict their diets. If a physician or other licensed health-care provider determines that a child's food allergies may result in severe, life-threatening (anaphylactic) reactions, then the child's condition will meet the definition of a disability, and the prescribed substitutions must be made by the District. In order to do so, the school nutrition program must receive a signed statement by the physician or other licensed health-care provider containing the following information:

The child's food allergy that constitutes a disability: _____

_____

An explanation of why the disability restricts the child's diet: _____

_____

The major life activity affected by the disability: _____

_____

The food(s) to be omitted from the child's diet: _____

_____

The food or choice of foods that must be substituted: _____

_____

Physician Information:

Name: _____

Address: _____

Phone Number: _____

Physician Signature: _____ Date: _____

For Office Use Only:

Date form was received by the school:_____ Campus Personnel Received: _____

Student Name: _____ Date of Birth: _____

Grade: _____ Student ID #: _____

EMERGENCY FOOD ALLERGY ACTION PLAN (EFAAP)

Name: _____ **D.O.B.:** ____/ /____

Allergy to: _____

Weight: _____lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

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, 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**

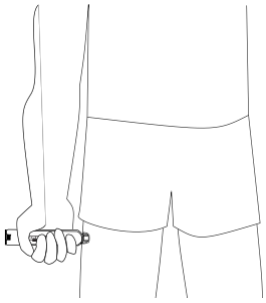
TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

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.**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

DEY™ and the Dey logo, EpiPen™, EpiPen 2-Pak™, and EpiPen Jr 2-Pak™ are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

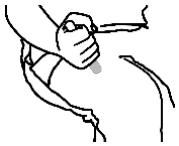
Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

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: _____

Other Emergency Contacts

Name/Relationship: _____

Name/Relationship: _____

Form provided courtesy of FAAN (www.foodallergy.org)

NOTICE OF STUDENT WITH A DIAGNOSED SEVERE FOOD ALLERGY

(Provide this form to ALL Substitutes who will be working on the campus.)

This campus has students who have been diagnosed with a severe food allergy. A severe food allergy is an allergy that might cause an anaphylactic reaction. An anaphylactic reaction is a serious allergic reaction that is rapid in onset and may cause death. You must check the appropriate substitute folder provided by the classroom teacher for information regarding whether specific students in the class have been diagnosed with a severe food allergy. All health information is confidential.

If there is a student with a diagnosed food allergy in the class, please contact the health clinic personnel for CISD procedures on food allergy management.

NOTICE OF STUDENT WITH A DIAGNOSED SEVERE FOOD ALLERGY

(Provide this form to ALL Parents, Volunteers, etc.)

Dear _____,

A student in the _____ *(class, named organization, named activity, or other)* has been diagnosed with a severe food allergy to _____ *(insert food allergy)*. A severe food allergy is an allergy that might cause an anaphylactic reaction. An anaphylactic reaction is a serious allergic reaction that is rapid in onset and may cause death.

For information regarding CISD food allergy procedures, please contact the Crowley Independent School District School Health Coordinator at 817-297-3018.

Sincerely,

_____ _____

Principal Date

ANAPHYLAXIS INCIDENT REPORT FORM

Student name: _____ Date of birth: _____

Grade: _____

Date of incident: _____

If known, the location and source of the allergen exposure:

_____

Emergency action taken (attach additional pages if more space is needed):

_____

_____

_____

_____

Were emergency services contacted?

☐ Yes ☐ No

Was an epinephrine auto-injector used?

☐ Yes ☐ No

If yes, who administered the epinephrine?

☐ Student (self-administration)

☐ Staff (provide name and position title): _____

☐ Other: _____

Are any changes to procedures recommended?

_____

_____

_____

Signature: _____ Date: _____

Received By: _____ Date: _____

(*Send to the Health Services Coordinator*)

INDIVIDUALIZED HEALTH-CARE PLAN

Note: If applicable, a student's individualized health-care plan must be coordinated with his or her Section 504 plan. [See FB for information regarding the application of Section 504 of the Rehabilitation Act to students who qualify for individualized health-care plans.]

Student name: _____ Date of birth: _____

Grade: _____

Primary health concerns/diagnoses: _____

_____

_____

Secondary health concerns/diagnoses: _____

_____

_____

Treating physician(s) information:

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Current medications* [see FFAC]:

_____

_____

_____

*Attach the Request for the Administration of Medication at School and/or the Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication, found at FFAC(EXHIBIT), as necessary.

Medical equipment:

_____

_____

_____

Diagnosis:	Assessment:	Goal:	Implementation / Intervention**:	Anticipated outcome:	Evaluation:

**Attach an emergency health plan related to student's diagnosis, if necessary.

Effective date: _____

Parent's signature: _____ Date: _____

Nurse's signature: _____ Date: _____