Clarendon CISD
Food Allergy Management Forms

Form A Request for Food Allergy Information
Form B Statement Regarding Meal Substitutions or Modifications
Form C Food Allergy Action Plan/Emergency Care Plan
Form C Food Allergy Action Plan/Emergency Care Plan (Spanish)
Medical Release & Medication Authorization Form
Notice of Student with a Diagnosed Severe Food Allergy (for Substitute Teachers)
Notice of Student with a Diagnosed Severe Food Allergy (for parents & classroom volunteers)
Anaphylaxis Incident Report Form
Individualized Health-Care Plan (Exhibit F)

Form A

Clarendon CISD

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. Additional information regarding food allergies, including maintaining records related to a student's food allergies, can be found at FFAF (LOCAL) in the Clarendon CISD Board Policy Manual at clarendonisd.net.

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.

"Food intolerance" means an unpleasant reaction to a food and is not life-threatening.

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.

☐ **No information to report (complete student name, grade, and parent signature only)**

Food:	**Nature of allergic reaction to the food:**	**Intolerance? Or Severe/ Life threatening?**

TO REQUEST A SPECIAL DIET OR MODIFICATION OF A MEAL PLAN, OR TO PROVIDE OTHER INFORMATION FROM YOUR DOCTOR ABOUT YOUR CHILD'S FOOD ALLERGY, YOU MUST CONTACT THE SCHOOL NURSE OR SCHOOL ADMINISTRATOR.

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.

Student name: _____ Date of birth: _____ Grade: __

Parent/Guardian name: _____

Home/Cell phone: _____Work phone: _____

Parent/Guardian Signature: _____ Date: _____

Date form was received by the school:_____

Form B

Clarendon CISD

Statement Regarding Meal Substitutions or Modifications

The United States Department of Agriculture regulations require substitutions or modifications in school meals for children whose severe food allergies/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 District must make the prescribed substitutions.

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. This form may be completed, signed, and dated by your child's doctor or a faxed physician's statement indicating the following information may be submitted to Debbie Thompson, Clarendon CISD School Nurse (fax- 874-2082).

Student Name _____ Date of Birth _____
Grade _____ School Year 20___-20___

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 may be substituted _____

PHYSICIAN INFORMATION	
NAME:	
ADDRESS:	
PHONE:	
FAX:	
PHYSICIAN'S SIGNATURE:	**DATE:**

Please return required forms as soon as possible, but no later than _____.

For additional information, please contact:
Debbie Thompson
Clarendon CISD School Nurse
80φ.874.3855
thompson.debbie@clarendonisd.net
Fax 806.874.2082

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**

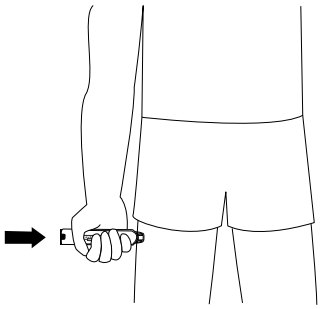
TURN FORM OVER

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**

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

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: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

Plan de Acción en Alergia a Alimentos

Plan de Emergencia

Nombre:_____ **Fecha de Nacimiento:** ___/__/___

Alergias: _____

Peso: _____ Kg./lbs. **Asma:** ☐ Sí (mayor riesgo de reacción severa) ☐ No

Ponga la foto del estudiante aquí

Extremadamente sensible a los siguientes alimentos:

COMO PROCEDER: _____

☐ Administrar Epinefrina inmediatamente ante CUALQUIER síntoma que se presente si se sospecha de haber ingerido el alergeno.
☐ Administrar Epinefrina inmediatamente si se confirma la ingesta del alergeno, aunque no se presente ningún síntoma.

SINTOMAS SEVEROS tras haber ingerido un alergeno:

Uno o más de los siguientes:
PULMON: Falta de aire, sibilancias, tos repetitiva
CORAZON: palidez, cianosis (coloración azul de la piel), desmayo, pulso débil, mareo, confusión.
GARGANTA: ardor, dificultad para tragar o respirar.
BOCA: inflamación obstructiva (lengua y/o labios)
PIEL: sarpullido - reacción alérgica en la piel

O **la combinación** de síntomas en diferentes partes del cuerpo:
PIEL: urticaria/ronchas, picor, sarpullido, inflamación (ej: ojos, labios)
ESTOMAGO: vómito, dolor

1. **INYECTAR EPINEFRINA INMEDIATAMENTE**
2. Llamar al 911
3. Comenzar seguimiento del paciente (ver indicaciones abajo)
4. Administrar medicamentos adicionales:*
   a. Antihistamínicos
   b. Broncodilatador inhalado, en caso de asma

*Los antihistamínicos & inhaladores/broncodilatadores no están indicados para el tratamiento de una reacción alérgica severa (anafilaxia). USAR EPINEFRINA

SINTOMAS LEVES SOLAMENTE:

BOCA: picor en boca
PIEL: sarpullido alrededor de la boca o cara, picor leve
ESTOMAGO: náuseas leves, malestar general

1. **ADMINISTRAR ANTIHISTAMINICO**
2. Permanecer con el estudiante; alertar a un médico y avisar a los padres.
3. Si los síntomas progresan (ver arriba), USAR EPINEFRINA
4. Comenzar seguimiento (ver indicaciones abajo)

Medicación/Dosis

Epinefrina (marca y dosis): _____
Antihistamínico (marca y dosis): _____
Otro (por ej., inhalador-broncodilatador si es asmático): _____

Seguimiento

Permanecer con el estudiante; alertar a un médico y a los padres. Comunicar al personal de emergencias que se le administró epinefrina; Pedir una ambulancia que cuente con epinefrina; Anotar la hora en que se administró la epinefrina. Se puede administrar una segunda dosis de epinefrina a los 5 minutos o más de la primera dosis en caso de que los síntomas persistan o reaparezcan. En caso de reacción severa, procurar mantener al estudiante acostado boca arriba con las piernas levantadas. Se debe administrar la medicación aunque no se pueda contactar con los padres. Ver modo de administración del autoinyector al reverso/detrás.

_____ **Firma de los padres** _____ **Fecha** _____ **Firma del médico** _____ **Fecha**

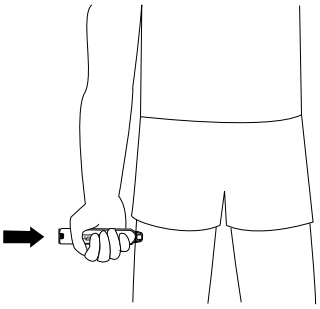
Dé la vuelta al documento

Documento proporcionado por cortesía de FAAN (www.foodallergy.org) 2/2012

Como aplicar el EpiPen Auto-inyector y el EpiPen Jr Auto-inyector

1. **Primero, saque el EpiPen Auto-inyector del estuche de plástico donde está guardado.**
2. Quite la tapa de seguridad azul

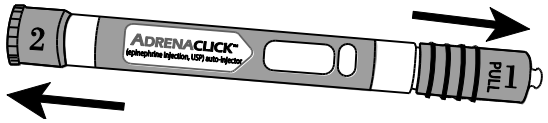
3. Sostenga el EpiPen con la punta naranja cerca de la parte externa del muslo (siempre aplicarlo en el muslo)

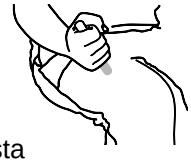


4. Aplique clavando enérgicamente la punta naranja contra el muslo. Manténgalo contra el muslo durante aproximadamente 10 segundos. Retire el EpiPen Auto-inyector y dé un masaje en la zona durante otros 10 segundos.

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Pasos para aplicar Adrenaclick™ 0.3 mg y Adrenaclick™ 0.15 mg





Quitar las dos tapas **GRISES** marcadas como “1” y “2”.

Colocar la punta redonda **ROJA** en la parte externa del muslo, presionar con fuerza hasta que penetre la aguja. Mantener 10 segundos, luego retirar.

Un Kit de tratamiento de emergencia ante reacciones alérgicas debe siempre contener al menos 2 dosis de epinefrina, otros medicamentos indicados por el médico del estudiante y una copia de su plan de acción ante reacciones alérgicas alimentarias.

El kit debe acompañar al estudiante si sale de la escuela (ej: viaje/excursión escolar).

Contactos

Llamar 911 (Servicio de Urgencias: (___)_____-_____) Médico:_____Número de teléfono: (___)_____-_____

Padres:_____ Número de teléfono: (___)_____-_____

Otros contactos en caso de emergencia:

Nombre/Relación: _____ Número de teléfono: (___)_____-_____

Nombre/Relación: _____ Número de teléfono: (___)_____-_____

CLARENDON INDEPENDENT SCHOOL DISTRICT
****** MEDICAL AUTHORIZATION ******

Student's Name:_____Date:_____

Street Address:_____ Home Phone:_____

City:_____D.O.B.:_____ Grade:_____

To PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls:

PARENT / GUARDIAN	DAYTIME PHONE #	RELATIONSHIP
1._____		
2._____		

EMERGENCY CONTACT
(If parent / guardian listed above cannot be reached):

NAME	STREET ADDRESS	DAYTIME PHONE#
1._____		
2._____		

I, the undersigned, do hereby authorize the officials of Clarendon Independent School District to contact directly the person named in this authorization, and do authorize _____
Physician
or_____ to render such treatment as may be deemed necessary in an
Hospital
emergency, for the health of my child. In the event physicians, other persons named in the authorization, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for my child.

_____ _____
Student's Name Signature of Parent/Guardian

Please list any physical condition or health issue that affects your child that you think would be important for the school to know. Also, please list medications, if any, that your child is currently taking or allergies that your child has.

_____

Medication Administration Form

Student Name_____

Student Grade_____

Please check which of the following over the counter medications that are allowed to be administered to your child at school. All allowed medications will be administered according to the label on the bottle. The school has some supplies for an emergency, but ***parents are expected to provide any regularly scheduled or frequently taken medications***.

___Tylenol

___Ibuprofen

___Pepto-Bismol

___Imodium

___Tums/Rolaids

___Benadryl

___Cold & Sinus medicine

List any medications that you will be bringing to school.

Name of Medication Amount Time or frequency

_____
_____
_____
_____
_____
_____
_____

_____ _____
Parent Signature Date

Debbie Thompson, LVN
School Nurse

Clarendon Public Schools

PO Box 610 Clarendon, Texas 79226 FAX: 806-874-2579

MONTY HYSINGER, Superintendent
806-874-2062

LARRY JEFFERS
High School Principal
806-874-2181

JOHN TAYLOR
Junior High Principal
806-874-3232

MIKE WORD
Elementary Principal
806-8743855

Clarendon CISD Substitute Teacher:

NOTICE OF STUDENT WITH A DIAGNOSED SEVERE FOOD ALLERGY

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 campus principal or school nurse for District procedures on food allergy management.

Clarendon Public Schools

PO Box 610 Clarendon, Texas 79226 FAX: 806-874-2579

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NOTICE OF STUDENT WITH A DIAGNOSED SEVERE FOOD ALLERGY

(To classroom parents, volunteers, etc.)

Dear _____,

A student in _____ has been diagnosed with a severe food allergy to _____. 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. Your cooperation is requested with the following steps in order to provide a safe school environment for all students at Clarendon CISD:

1) Pease keep this student's health in mind by sending an alternative to _____ when providing snacks for this class/group;
2) _____

For information regarding Clarendon CISD food allergy procedures, please contact the campus principal or school nurse.

Sincerely,

_____ _____
Date

Clarendon Cisd

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: _____

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: _____