Novi Community School District
Allergy Management Plan

Insert Photo with authorization from parent/guardian

Student's Name: _____ School Year: _____

School Attending: _____ Grade: _____ Teacher: _____

Reviewed by: _____ Date: _____
(Healthcare Provider Signature)

Acknowledged by: _____ Date: _____
(Parent/Guardian Signature)

Phone: _____ Cell #1: _____ Cell #2: _____

Acknowledged by: _____ Date: _____
(District Nurse Signature)

STUDENT HAS ALLERGY TO: _____

STUDENT HAS ASTHMA: Circle YES NO (***If yes, student has an increased risk for anaphylaxis)***

Medication	Dose/Route

■Signs of Allergic Reaction■

MINOR SYMPTOMS

Mouth: Mild itching, rash or swelling
Skin: Hives, mild itching, rash, swelling
Gut: Mild nausea/upset stomach

Give ► Antihistamine (BENADRYL)

After giving antihistamine stay with student, alert parent if symptoms progress give EPINEPHRINE
****The severity of symptoms can quickly change- All of the above symptoms can potentially progress to a life threatening situation* ***VERY QUICKLY!***

LIFE THREATENING SYMPTOMS NOTED OR KNOWN INGESTION:
ANY OF THE FOLLOWING:

Lung: Shortness of breath, repetitive coughing, wheezing
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Swelling of lips or tongue
Skin: Many hives over body
Gut: Vomiting, diarrhea, cramping

► *Give Epinephrine (EPI-PEN)*

PARENT/GUARDIAN:

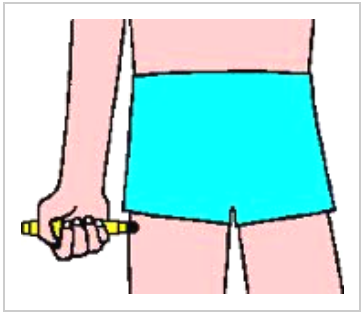
I request and give permission for (name of student)_____,
to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name, must be current and be approved by student's physician.

_____ Date: _____
Parent/Guardian Signature

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of the student's counselor or building principal.

DIRECTIONS FOR EPIPEN USE:
STEPS TO ADMINISTER THE EPI-PEN:

1. Pull off blue safety release cap
2. Hold orange tip near outer thigh (always apply to thigh)
3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions
4. Hold in place and count to 5. Note: The EPI-PEN unit should be removed and taken with you to the Emergency room.
5. Massage the injection area for 10 seconds
6. Call 911
7. Parent/Guardian will be notified when the EPI-PEN is administered
8. 2nd Epi pen should be given 5-10 minutes after the first if symptoms are not improving



DIRECTIONS FOR Auvi-Q USE:
STEPS TO ADMINISTER THE EPI-PEN:

1. Auvi-Q has voice instructions.
2. Remove safety cap.
3. Follow directions.
4. Call 911
5. Parent/Guardian will be notified when the Auvi-Q is administered

Bus Information to be completed by Parent/Guardian:

Medication is to be available on the bus: Please circle YES NO

If Medication ***IS*** to be available on the bus, I _____, parent/guardian of:

_____ understand that I must provide an extra medication to be carried to and from school in the front pocket of the backpack. Transportation will be notified.

Acknowledged by District Licensed Nurse: _____ Date: _____

Total # of EPI-PEN(S) supplied to district: _____ Exp date: _____

Benadryl supplied: _____ Exp date: _____

Revised 11/19 ja

Michigan Department of Education
Office of Health and Nutrition Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant. See back side for instructions.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐Participant has a disability and *requires* a special meal or accommodation (Refer to instructions on reverse side of this form). Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to religious, cultural, economic, or other preferences. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests but are not required to do so. Any meals provided must fully meet the meal pattern. **A school administrator or parent/guardian may sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), nurse, school administrator, or parent/guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation- use extra pages as needed; see instructions on reverse side*)

12. Specific foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed; see reverse side*)

A. Food(s) To Be Omitted: **B. Suggested Substitution(s)**

_____

_____

13. Indicate Texture:

☐Regular ☐Chopped ☐Ground ☐Pureed

14. Adaptive Equipment Needed (if applicable):

15. Signature of Parent/Guardian:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority (if applicable):	20. Printed Name: (include credentials and license/registration number)	21. Telephone	22. Date

This institution is an equal opportunity provider.

Revised 9/2018

Michigan Department of Education
Office of Health and Nutrition Services

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box to indicate whether participant has a disability and is requesting accommodation or does not have a disability but is requesting special accommodation, and/or fluid milk substitution. Non-disability accommodations are at the discretion of the district and must meet the appropriate meal pattern.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example, *"Allergy to peanuts causes a life-threatening reaction."*
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example, *"All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."*
12. **Specific food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted and what must be offered in their place. Attach additional pages, if needed. For example, *Foods to be Omitted: "peanut butter"* or *"any food containing gluten"* and *Foods to Be Substituted: "peanut-free soy butter or sunflower butter"* or *"gluten-free alternative. If a similar product to what is on menu is not available without gluten, provide a reasonable substitute that does not contain gluten."*
13. **Indicate texture:** Check a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Telephone:** Primary, preferred contact phone number for parent/guardian.
18. **Date:** Date parent/guardian signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation, if it is for a disability or medical condition. If it is not a medical issue, leave this section blank or write "N/A."
20. **Printed Name:** Print name of medical authority, if applicable, including credentials and license number. See #19, above.
21. **Telephone:** Telephone number of medical authority. See #19, above.
22. **Date:** Date medical authority signed form. See #19, above.

Disability Definition: The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). More Information regarding the ADAAA, which expanded the definition of disability, see the Comparison of ADA and ADAAA sheet (http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf).

Special Dietary Needs Management in Schools: For detailed guidance on management of special dietary needs in schools, please see the U.S. Department of Agriculture (USDA) manual, *Accommodating Children with Disabilities in School Meal Programs* in "Guidance and Handbooks" section (https://www.fns.usda.gov/school-meals/guidance-and-resources).