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:

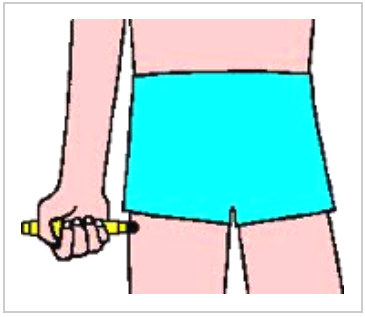
I request and give permission for (name of student)_____,
to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools 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

Special Diet Statement

Why am I being asked to fill out this form?

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.* According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors are not required to accommodate special dietary requests that are not a disability. This includes requests related to religious or moral convictions or personal preference. **If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.**

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. **Updates to this form are required only when a participant's needs change**.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: NCSD Food & Nutrition Department

Participant Information:

Participant's Full Name: _____ Today's Date: _____

Date of Birth:_____

Name of School/Center/Site Attended: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number:_____

Required Information: Dietary Accommodation

1. List the food to be avoided:

   _____

2. Briefly explain how exposure to this food affects the participant:

   _____

3. List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

☐ Other Dietary Modification or Additional Instructions (Describe): _____

*School Nutrition Program –7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4).

Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print):_____Date:_____

Signature:_____Clinic/Hospital:_____

Phone Number:_____Fax Number: _____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to_____**(program name)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional**: 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 authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:_____Date: _____

OR Participant's Signature (Adult Day Care ONLY): _____

Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online (http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov