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Note: Additional resources and supporting materials, including sample Food Allergy Action Plans (FAAPs) and Emergency Action Plans (EAPs), can be found on the Texas Department of State Health Services (TDSHS) website.[1]

Samples regarding Request for Administration of Medication at School and Self-Medication Authorization Form can be found in the TDSHS *Guide to Medication Administration in the School Setting.*[2]

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[1] Texas Department of State Health Services: https://www.dshs.state.tx.us/schoolhealth/default.shtm
[2] TDSHS Guide to Medication Administration in the School Setting: https://www.dshs.texas.gov/schoolhealth/schnurs.shtm

Exhibit A—Letter Requesting Additional Documentation for Student Identified as Having a Severe Food Allergy

Note to Administrator: Education Code 38.0151(g) requires a district to include on any forms used to request information from a parent enrolling a child with a food allergy information on accessing the District's website that provides the summary of the Texas Department of School Health Services' (TDSHS) *Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis* and instructions on how to access the complete *Guidelines*. Insert the link to this information below.

Dear Parent or Guardian:

You have disclosed that _____ *(student's name)* has a severe food allergy. The District requires additional information in order to take necessary precautions for the student's safety and to authorize treatment of the student in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Request for the Administration of Medication at School
2. Authorization to Secure Emergency Medical Treatment of a Student
3. Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication
4. Statement Regarding Meal Substitutions or Modifications
5. Food Allergy Action Plan (FAAP)
6. Emergency Action Plan (EAP)

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

The District has a food allergy management plan based on the state-developed *Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis*.[1] A link to the complete guidelines may be found posted on the District's website at, https://www.rockdaleisd.net/apps/pages/index.jsp?uREC_ID=345090&type=d&pREC_ID=759499.

Sincerely,

_____

(Principal, nurse, District food allergy coordinator, or _____)

[1] TDSHS Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis: https://www.dshs.texas.gov/uploadedFiles/Content/Prevention_and_Preparedness/school-health/SHAC/Guidelines-Food%20Allergy-Final.pdf

Exhibit B—Statement Regarding Meal Substitutions or Modifications

Note: Information regarding accommodating students with special dietary needs can be found on the Texas Department of Agriculture (TDA) website.[1]

The U.S. Department of Agriculture regulations require substitutions or modifications in school meals for students whose disabilities restrict their diets. If a physician or other licensed health-care provider determines that a student's food allergies may result in severe, life-threatening (anaphylactic) reactions, then the student'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 student's food allergy that constitutes a disability: _____

_____

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

_____

The major life activity affected by the disability: _____

_____

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

_____

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

_____

Physician information:

Name: _____

Address: _____

Phone number: _____

Physician's signature: _____

Date: _____

For Office Use Only

Date form was received by the school: _____

Student's name: _____

Date of birth: _____

Grade: _____

[1] Texas Department of Agriculture: http://www.squaremeals.org/Portals/8/files/ARM/Section13_Accommodation_V001_180122.pdf

Exhibit C—Notice of Student with a Diagnosed Severe Food Allergy

[Provide this form to 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 campus nurse for *District* procedures on food allergy management.

Exhibit D—Notice of Student with a Diagnosed Severe Food Allergy

[Provide this form to parents, guardians, volunteers, and the like.]

Dear _____,

A student at the _____ *(class/campus, 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. Please help us support a safe school environment by following *(District or campus)* food allergy procedures prior to bringing an item to _____ *(class/campus, named organization, named activity, or other)* that may trigger this allergy.

For information regarding *District* food allergy procedures, please contact the District nurse.

Sincerely,

Principal: _____ Date: _____

Exhibit E—Anaphylaxis Incident Report Form

Student's 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?

_____

_____

Principal: _____ Date: _____

Received by: _____ Date: _____

Exhibit F—Individualized Health-Care Plan

Note: If applicable, a student's individualized health-care plan (IHP) 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's 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 Administration of Medication at School and/or the Self-Medication Authorization Form and any other applicable form found in the *Guide to Medication Administration in the School Setting*[1] on the TDSHS website.

Medical equipment:

_____

_____

_____

Diagnosis	Assessment	Goal	Implementation / Intervention**	Anticipated outcome	Evaluation

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

Effective date: _____

Signature of parent or guardian: _____ Date: _____

Nurse's signature: _____ Date: _____

[1] TDSHS Guide to Medication Administration in the School Setting: https://www.dshs.texas.gov/school-health/schnurs.shtm