ALVARADO ISD OPERATIONS DEPARTMENT
PO Box 387 ♦ 110 South Bill Jackson Drive
Alvarado, TX 76009
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FOOD ALLERGY MANAGEMENT PLAN

Identification

Upon registration the parent will be provided a copy of the Request for Food Allergy Information Form (Exhibit A) to provide them with an opportunity to disclose whether their child has a food allergy or severe food allergy. If the parent indicates that the child has a severe food allergy (food anaphylaxis) on their form, they will be given a letter with instructions on how they can assist the school in developing an Individualized Health Care Plan for their child (Exhibit B) and two forms forms that they will need to have their child's doctor complete (Exhibit C & Exhibit D).

Exhibit C is the "Eating and Feeding Evaluation: Special Dietary Needs" form. This form is for children who require substitutions or modifications to school meals because of the restrictions associated with their disability. It would be completed for a child with a disability as defined under either Section 504 of the Rehabilitation Act or Part B of the Individuals with Disabilities Education Act or for a child with a severe food allergy whose physician certifies that the child's food allergy may result in a severe, life-threatening (anaphylactic) reaction. This form must be completed by the child's doctor.

Exhibit D is the "Allergy Health Care Action Plan". The purpose of this form is to assist the staff in addressing an allergic reaction.

Development, Communication, Implementation, and Monitoring of the Food Allergy Action Plan

Once the school has received Exhibit C, the school will review the form for the required information, and a 504 or ARD committee meeting may then be scheduled to develop an Individual Education Plan to address the child's special meal requirements. The Alvarado ISD Child Nutrition Department will be present at the ARD or 504 meeting to assist in the development of the IEP. Once the IEP is developed, a copy of the IEP and Exhibit C will be placed in the cafeteria along with an allergy information card that will be completed by the CN Director. Exhibit D will be given to the school nurse. If a child has a food allergy, the school will only be able to make substitutions or modifications to the child's meal when the child's allergy is properly documented by a physician as being a severe food allergy (food anaphylaxis) and approved by the ARD or 504 committee.

Training

Child nutrition staff and school nurses will be provided training on food allergies and anaphylaxis. Other district staff will be provided Awareness training regarding signs and symptoms of food allergies and emergency response in the event of an anaphylactic reaction.

Review

The Food Allergy Management Plan will be reviewed annually and a post-anaphylaxis review will be held each time we have severe food allergy reaction.

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:	**Nature of allergic reaction to the food:**

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: _____

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Dear Parent,

We appreciate you taking the time to fill out the "Request for Food Allergy Information" form when you registered your child. On your form, you indicated that your child may have a food allergy. We have attached to this letter two forms that you may want to fill out.

The first form is the "Eating and Feeding Evaluation: Special Dietary Needs" form. This form is for children who require substitutions or modifications to school meals because of the restrictions associated with their disability. It would be completed for a child with a disability as defined under either Section 504 of the Rehabilitation Act or Part B of the Individuals with Disabilities Education Act or for a child with a severe food allergy whose physician certifies that the child's food allergy may result in a severe, life-threatening (anaphylactic) reaction. This form must be completed by the child's doctor. Once this form is received, the school will review the form for the required information, and a 504 or ARD committee meeting may then be scheduled to develop an Individual Education Plan to address the child's special meal requirements. **The Alvarado ISD Child Nutrition Department will not be able to make substitutions or modifications to your child's meal without having a completed copy of this form and the resulting IEP on hand.**

The second form is the "Allergy Health Care Action Plan". The purpose of this form is to assist the staff in addressing an allergic reaction.

Thank you,

Mark Ratcliff

Figure 1. Eating and Feeding Evaluation: Children with Special Dietary Needs

PART A				
Student's Name			**Age**	
Name of School	**Grade Level**	**Classroom**		
Does the Child have a Disability? If Yes, describe the major life activities affected by the disability.			**Yes** ☐	**No** ☐
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.			**Yes** ☐	**No** ☐
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.			**Yes** ☐	**No** ☐
If the child does not require special meals, the parent can sign at the bottom of this form and return the form to the school food service.				
PART B				
List any dietary restrictions or special diet.				
List any allergies or food intolerances to avoid.				
List foods to be substituted.				
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All". **Cut up of chopped into bite size pieces:** **Finely ground:** **Pureed or Blended:**				
List any special equipment or utensils that are needed.				
Indicate any other comments about the child's eating for feeding patterns.				
Parent's Signature		**Date:**		
Physician or Medical Authority's Signature:		**Date:**		

Figure 2. Information Card

Student's Name	**Teacher's Name**
Special Diet or Dietary Restrictions	
Food Allergies or Intolerances	
Food Substitutions	
Foods Requiring Texture Modifications: **Chopped:** **Finely Ground:** **Pureed or Blended:**	
Other Diet Modifications:	
Feeding Techniques:	
Supplemental Feedings:	
Physician or Medical Authority: **Name:** **Telephone:** **Fax:**	
Additional Contact: **Name:** **Telephone:** **Fax:**	**Additional Contact:** **Name:** **Telephone:** **Fax:**
School Nutrition Program Representative/Person Completing Form: **Title:** **Signature:**	**Date:**

Alvarado ISD – School Health Services

Allergy Health Care Action Plan

Student: _____ DOB: _____School Year/Grade: _____

Allergy: _____

Weight: _____ lbs Asthma: ____YES (Higher risk for severe reaction) ____ NO

SYMPTOMS:	**Medication Administration (completed by physician)**	
If a food allergen has been ingested but no symptoms	___Epinephrine	___Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	___Epinephrine	___Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	___Epinephrine	___Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	___Epinephrine	___Antihistamine
Throat* : Tightening of throat, hoarseness, hacking cough	___Epinephrine	___Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	___Epinephrine	___Antihistamine
Heart*: Thready pulse, low blood pressure, fainting, pale, blueness	___Epinephrine	___Antihistamine
Other*: _____	___Epinephrine	___Antihistamine
If reaction is progressing (several of the above)	___Epinephrine	___Antihistamine

The severity of symptoms can change quickly. * All above symptoms can potentially progress to life threatening.

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine:_____

Medication/dose/route

Other Medications/Instructions: _____

_____

Medication/dose/route

MONITORING:

Stay with student; alert EMERGENCY MEDICAL SERVICES - 911 and parent. Tell emergency medical services 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.

_____ _____ _____

Physician Signature/Stamp **Date** **Office Number**

_____ _____ _____

Parent/Guardian Signature **Date** **Contact Number**

EMERGENCY CONTACTS:

Parent/Guardian:_____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Source: Food Allergy & Anaphylaxis Network (2010) http://foodallergy.org/school.html

Avarado ISD – School Health Services

Allergy Health Care Action Plan

Student: _____ DOB: _____ School Year/Grade: _____

The above named student has been instructed in the proper use of the EpiPen and fully understands how to administer.
I have completed the allergy action plan on this student to have on file in the school health office (other side of form).

_____ _____ _____

Physician Signature/Stamp **Date** **Office Number**

I have been instructed in the proper use of my prescription EpiPen and fully understand how to administer. I will not allow another student to use my EpiPen under any circumstances. I also understand that if another student uses my EpiPen, the privilege of carrying it with me may be revoked. I understand the school nurse will be notified immediately if I should require the use of my EpiPen, so that EMERGENCY MEDICAL SERVICES - 911 can be obtained.

_____ _____

Student Signature **Date**

I herby request that the above names student, be allowed to carry his/her EpiPen on the AISD campus (es), and be responsible for its use as needed. I understand that the parent/guardian accepts the legal responsibility should the EpiPen be lost, given or taken by a person other that the student for whom it is prescribed. If this should happen, the privilege of carrying the EpiPen may be revoked, I understand that AISD has no legal responsibility when the above named student administers his/her own medication. I understand that the campus nurse will be notified immediately if the EpiPen is administered, and EMERGENCY MEDICAL SERVICES - 911 will be obtained.

I give permission for the information contained on the HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physicians orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever this is any change in the student's health status or care.

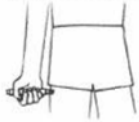
_____ _____ _____

Parent/Guardian Signature **Date** **Contact Number**

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

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

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

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

Once EpiPen® or Twinject™ is used, call EMERGENCY MEDICAL SERVICES - 911. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

Source: Food Allergy & Anaphylaxis Network (2010) http://foodallergy.org/school.html