Letter Requesting Additional Documentation For Student Identified As Having A Severe Food Allergy

Dear Parent or Guardian:

You have disclosed that ________________________ 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. Food Allergy & Anaphylaxis Emergency Care Plan ("FARE" form)*;
2. LTISD Food and Nutrition Services Food Allergy/Intolerance Notification*;
3. Self-Carry/Administration of Medication Authorization*;
4. Request for Medication Administration; and
5. Release/Consent to Request Medical Information.

Forms noted with an asterisk must be completed and signed by an MD, DO, NP, or APRN. Please return these forms to your school nurse as soon as possible. Any additional information or documentation that will help assist the campus in recognizing the signs and symptoms of an anaphylactic reaction that your student might experience is also greatly appreciated.

Sincerely,

LTISD Student Health Services

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ______________

Allergy to: ______________________________

Weight: ____________ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________________

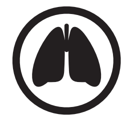
THEREFORE:

[ ] If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

[ ] If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

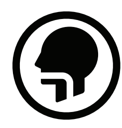
FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

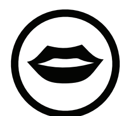


LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

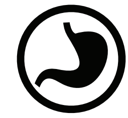


THROAT
Tight or hoarse throat, trouble breathing or swallowing

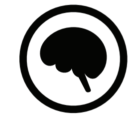


MOUTH
Significant swelling of the tongue or lips

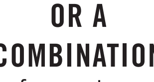
SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



OTHER
Feeling something bad is about to happen, anxiety, confusion



OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

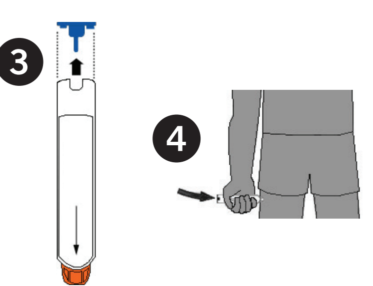
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

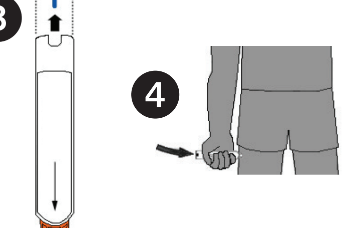
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it ‘clicks’.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it ‘clicks’.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ______________

PARENT/GUARDIAN: ______________________ PHONE: ______________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

Lake Travis ISD Food and Nutrition Services

Medical Meal Accommodations

This form is not required to be updated annually unless there is an update to your student's medical condition.

Part A: to be completed by parent/guardian	
Student Name: ______________________________________	**DOB:** _______________ **Student ID:** _______________ **Campus:** ____________ **Grade:** ___________________
Printed Parent/Guardian Name: ______________________________________	**Phone Number:** _______________________ **Email Address:** _______________________

Part B: MUST be completed by MD, DO, NP, APRN
All questions must be answered for any diet modifications or substitutions to be made in school meals.

1. **Does the child have a disability recognized by the Americans with Disabilities Act?**
❑ Yes ❑ No

2. **If the child does NOT have a disability, does the child have a food allergy or intolerance that results in an anaphylactic or adverse reaction when exposed to that specific food?**
❑ Yes ❑ No

3. **Please identify the disability, food allergy, or intolerance & describe the major life activities affected.**

4. **Check all foods that affect the child (if applicable):**
❑ **Fresh Dairy** (fluid milk, yogurt, cheese, etc.) ❑ **Baked Dairy** (as an ingredient in baked goods)
❑ **Fresh Eggs** (hard boiled eggs, scrambled eggs, etc.) ❑ **Baked Eggs** (as an ingredient in baked goods)
❑ **Peanuts** ❑ **Tree Nuts** ❑ **Wheat/Gluten** ❑ **Soy** ❑ **Fish** ❑ **Shellfish** ❑ **Sesame**
❑ Other:____

5. **Please describe meal accommodation to be made:** (foods to be omitted, modified, or substituted)

________________________________	______________________________	____________
Physician's Printed Name or Stamp	**Physician's Signature**	**Date**

By submitting this form, you are giving consent for LTISD FANS to consult with the child's MD, DO, NP, or APRN about this condition. If you do NOT want LTISD FANS to contact the medical office, initial here ______.

I have read the above orders and agree with this plan of care for my child.

______________________________	______________
Parent Signature	**Date**

Completed forms should be submitted to your campus nurse to be scanned and emailed to Food and Nutrition Services. *Please allow up to 7 business days for processing.* For information regarding Lake Travis ISD FANS meal accommodations, please visit the Food and Nutrition Services website (https://www.ltisdschools.org/foodallergy). Parents may remove food restrictions by way of written consent; any additions or increases in severity of medical meal accommodations must be amended by MD, DO, NP, or APRN with a new form.

Updated: 10-31-23

Self-Carry/Administration of Medication Authorization

A responsible, trained student is permitted to carry and/or self-administer medication on his/her person for immediate use in a life-threatening situation with a written order from a physician/prescribing health care provider, parent/guardian request, and school nurse and principal approvals.

Student: _____________________________ Grade: _______ Date of Birth: _________________

Condition for which medication is administered: ____

Name of medication: ____ Dose: ____________________

Method of administration for medication: ____

Timing /Indication for administration of medication: ____

Side effects to be noted/reported: ____

Other recommendations:____

Dates of administration: From ________ to _________ (not to exceed one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician: _________________________________ Telephone(s): ________________________________

Physician's Signature: ____________________________________ Date: ______________

Parent/Guardian Authorization

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, the medication name, date of the original prescription, strength and dosage of the medication, and directions for use. No more than a 30 day supply of the medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or the end of the medical order.

Parent Signature: ____ Date: __________

Student Signature: ____ Date: __________

Principal/School Nurse Approvals

We accept the parent request and physician statement above. We will permit/assist the student to be responsible with this self-carry medication, but reserve the right to withdraw the privilege if student shows signs of irresponsibility, or if there is a reported safety risk. In the event that a safety risk has been determined, the administration will contact parent/guardian as soon as possible.

School Nurse's Signature: ____ Date: _____________

Principal's Signature: ____ Date: _____________

Request for Medication Administration

Student: ______________________________ DOB __________ Grade: _____ Campus: ________

Medication: ____ Dose: ____________________

Take medication: □ by mouth □ via inhaler □ topical (cream) □ injection □ other _______

Condition for which medication is given: ____

To be given: □ Entire School Year - or - □ The following dates: ___ /___ /____ to: ___ /___ /____

When: □ At the following time(s): ______________ - or - □ As needed every _______ hours Special

considerations/side effects: ____

For Daily Medications: _____ Yes, please send on field trips

_____ No, please do not send on field trips

Other medications taken at home: ____

List any food or drug allergies: ____

Must be signed by a physician for any of these reasons:

□ prescription given more than 10 school days (daily medication)

□ any over-the-counter medication

Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.	
Signature:	Date:
Printed Name:	Phone:

Physician: I request that the student receive this medication during the school day as instructed above.	
Signature:	Date:
Printed Name:	Phone:

School: Medication was received by:		
Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date:

Release/Consent to Request Medical Information

Student Name ____

Date of Birth ______________ **Grade** ______ **Campus** ______________

Please authorize the person named below to request specified records containing confidential information regarding the above-named student.

From: Lake Travis Independent School District	To: ___________________________ Physician to whom the request is made
___________________________ Campus	___________________________ Phone number
___________________________ Address	___________________________ Address
___________________________ City/State/Zip	___________________________ City/State/Zip
___________________________ Fax	___________________________ Fax

Records to be released	**Purpose of Disclosure**
□ Medical History	Develop an appropriate health care plan
□ Physician's Orders	
□ On-going Communication	To clarify student's medical needs

____________________________________ at: _________________________
School Nurse Phone Number

□ Yes □ No I have been fully informed and understand the school's request for my consent, as described above. This information will be requested upon receipt of my written consent.

□ Yes □ No I understand that my consent is voluntary and may be revoked at any time.

_______________________________________ ______________________
Parent/Guardian Signature Date

____
Parent/Guardian Printed Name