SYCAMORE
COMMUNITY SCHOOLS
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District policy requires completion of the "Food Allergy Notification Form" by a **parent/guardian and a licensed physician or medical authority** if a life threatening food allergy or disability that requires a special diet or food has been diagnosed. Please note, an individual diagnosed with a life threatening food allergy or disability, as described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well of the USDA's *nondiscrimination regulation*, can be described as a person who has a physical or mental impairment that substantially limits one or more major life activities that all reasonable requests for food and beverage substitutions will be made so the student can eat.

The information in this form is shared with the Child Nutrition and Wellness Director, kitchen supervisor, school nurse, and school officials. The Child Nutrition and Wellness Director provides annual training to all child nutrition staff regarding food allergy awareness**.** All school nurses are also provided annual training and they then provide training for all staff within the building (custodians, educational assistants, teachers). Your child's student meal account will be updated with notation of the food allergy and special dietary needs with an associated alert for the cafeteria cashier during each transaction. This information will also be in the nurse's files. Parents may contact the Child Nutrition and Wellness directly if so desired for further clarification regarding menu substitutions. Parents may contact the school nurse to get more information on cafeteria seating and how you would like snacks/treats handled in the classroom.

Please remember that **both** the parent/guardian and the medical professional's signature are required for any dietary modifications/substitutions and use of medications. The substitution must be clear on the form and it must be within reason. Once the form has been completed it is not necessary to complete it again unless there are any changes. If the use of medications are required, the "Medication Order Form" must be completed and returned to the school nurse.

Thank you!

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# FOOD ALLERGY NOTIFICATION FORM

## PART A

***Part A:*** *To be completed by* ***Parent/Legal Guardian.***

| | |
|---|---|
| STUDENT LAST NAME: | STUDENT FIRST NAME: |
| STUDENT ID#: | SEX: M F |
| SCHOOL: | GRADE: |
| PARENT/GUARDIAN NAME: | CELL PHONE: |
| PARENT/GUARDIAN EMAIL ADDRESS: | HOME PHONE: |
| PHYSICIAN: | PHYSICIAN PHONE: |

Please note: An individual diagnosed with a life threatening food allergy or disability, as described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well of the USDA's *nondiscrimination regulation*, can be described as a person who has a physical or mental impairment that substantially limits one or more major life activities that all reasonable requests for food and beverage substitutions will be made so the student can eat.

**Does the child have a disability?** YES / NO

If YES, describe the major life activities affected by the disability.

**Does the child have any religious restrictions?** YES / NO

PLEASE NOTE: a physician signature is **not** required for religious food preferences.

If YES, please describe:

**Does the child have special nutritional or feeding needs?** YES / NO

If YES, please have Part B completed and signed by a ***licensed physician***

**If the child does not have a disability, does the child have special dietary needs?** YES / NO

If YES, please have Part B completed and signed by a recognized ***medical authority.***

## PART B

***Part B:*** *To be completed by a* ***licensed physician or medical authority*** *any time there is a change in the diagnosis regarding* ***food allergies or intolerances.*** *Please check* ***ALL FOODS to be avoided by the student in order to prevent a life-threatening reaction.***

**Please CIRCLE all signs and symptoms of an allergic reaction that apply:**

- Mouth — Itching & Swelling of the lips, tongue or mouth
- Throat — Itching and/or tightness in the throat, hoarseness, and hacking cough
- Skin — Hives, itchy rash, and/or swelling of the face or extremities
- Gut — Nausea, abdominal cramps, vomiting and/or diarrhea
- Lungs — Shortness of breath, persistent cough, and/or wheezing
- Heart — Rapid or weak pulse, passing out

**What was the date of the FIRST reaction, the symptoms, and the treatment?**

**Please make * notation if the following is a <u>SEVERE</u> or <u>LIFE-THREATENING</u> allergy.**

Substitutions outside of regular meal pattern can **ONLY** be made if form is signed by a medical authority.

**DAIRY ALLERGY:**

- ☐ Milk and UNCOOKED dairy products only (Ex: fluid milk, yogurt, cheese, etc.)
- ☐ Milk, dairy, and ALL milk products (This includes cooked and denatured milk products. Ex: breads, cookies, etc.)
- ☐ Lactose intolerance
- ☐ Not applicable

| **Foods to be omitted:** | **Substitutions:** |
|---|---|

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**EGG ALLERGY:**

- ☐ Eggs only (Ex: boiled, scrambled, individualized eggs)
- ☐ Eggs and ALL egg products (This includes cooked and denatured egg products. Ex. Breads, muffins, etc.)
- ☐ Not applicable

**Foods to be omitted:**

**NUT ALLERGY:**

- ☐ Peanuts (Ex: peanut butter & individualized peanuts)
- ☐ Tree nuts (This includes cashews, pistachios, walnuts, almonds, pecans, etc.)
- ☐ Foods processed in the same factory as peanuts/tree nuts
- ☐ Other _____
- ☐ Not applicable

**SOY ALLERGY:**

- ☐ Soy only (Ex: soy milk, soy yogurt, etc.)
- ☐ Soy and ALL soy products (This includes cooked and denatured soy products. Ex: taco meat, chicken tenders, etc.)
- ☐ Not applicable

**Foods to be omitted:**

**GLUTEN/WHEAT ALLERGY:**

- ☐ Wheat only
- ☐ Celiac Disease (This includes avoidance of products containing wheat, spelt, kamut, farro, durum, bulgar, semolina, barley, triticale, oats & rye)
- ☐ Non-celiac gluten sensitivity/gluten intolerance
- ☐ Not applicable

**Foods to be omitted:** **Substitutions:**

**FISH/SHELLFISH ALLERGY:**

- ☐ Finned Fish and ALL fish products (This includes fish oils, and whole fish products including pollock, salmon, tuna, and halibut)
- ☐ Crustacea (This includes shrimp, crab, and lobster)
- ☐ Mollusks (This includes clams, mussels, oysters, and scallops)
- ☐ Not applicable

**Foods to be omitted:**

**SESAME ALLERGY:**

- ☐ Sesame and all sesame containing products

**OTHER ALLERGIES, ADDITIONAL DIETARY RESTRICTIONS, OR SPECIAL DIETS:**

**Will your child require emergency medication at school?** YES / NO
If YES, the attached *Medication Order Form* must be on completed and returned to the school nurse

**How would you like snacks/treats handled in the classroom? (applies to grades K-6 only)**

***** FORM CAN NOT BE PROCESSED UNLESS IT IS SIGNED BY A PARENT/GUARDIAN AND A PHYSICIAN/MEDICAL AUTHORITY*****

*Once the form has been completed it is not necessary to complete it again unless there are changes.*

| | |
|---|---|
| **Parent/Guardian Signature:** | **Date:** |
| **Physician/Medical Authority Signature:** | **Date:** |

**- OFFICE USE ONLY -**

| | |
|---|---|
| Nurse Signature:<br>Date: | Child Nutrition Signature:<br>Date: |

## MEDICATION ORDER FORM

Please return the completed form to the school nurse

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District policy requires consent of the parent/legal guardian and a written order from the licensed prescriber before medication can be given to a student by school personnel. This includes over-the-counter medication. Medication must come to school in the original container with the affixed label from the pharmacist. Prescription medication must show the student's name, name of medication, dosage directions, licensed prescriber's name, and rx number (if there is one). A written order from the licensed prescriber is required for a student to carry an inhaler or Epi-Pen. The following information is necessary in order to comply with this policy. **All requested information and fields must be completed.**

### TO BE COMPLETED BY A LICENSED PRESCRIBER (M.D, DO, NP, DMD, DDS, etc):

**STUDENT NAME:** **STUDENT BIRTH DATE:**

**GRADE:** **HOMEROOM:** **TEACHER:**

This student is under my care for (diagnosis) _____

| Medication | Dosage | Time | Duration | Route | Side Effects to Notify Physician of |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Special Instructions:

_____

**Licensed Prescriber Signature:**_____ **Date:**_____

**Licensed Prescriber Office Phone:**_____ **Licensed Prescriber Address:**_____

### AUTHORIZATION FOR STUDENT POSSESSION AND USE of EPINEPHRINE AUTOINJECTOR (EpiPen, AuviQ) or INHALER:

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector or inhaler appropriately. I have provided the student with training in the proper use of the autoinjector or inhaler.

**Licensed Prescriber Signature:**_____ **Date:**_____

### TO BE COMPLETED BY THE PARENT / GUARDIAN:

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child. I also agree to:

1. Notify the school if the medication or dosage is changed, if alternate dosing is required (late arrival) or if stopped. (Note: If your child does not take a daily scheduled medication for more than 30 days, a new order from the doctor will be required)
2. Grant permission for the school nurse to confer with the above physician/medical authority regarding the child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs
3. Provide safe transportation of the medication to and from school. Medication must be given directly to a school official.
4. If authorization to carry Epi-Pen is completed by the physician/medical authority, the parent **must** provide a backup dose of Epi-Pen (Ohio Revised Code 3313.718) Emergency medical services will be called if Epi-Pen is administered.
5. If physician has written order for the student to carry an inhaler, the parent is requested to provide a backup inhaler
6. Parents are requested to contact the school nurse promptly, in the event that AM medication dosing is given later than typically scheduled and might conflict with a dose provided at school (i.e, late start days, inclement weather days, etc).

_____ Yes, I will provide a backup inhaler _____ No, I decline the need to provide a backup inhaler

**NOTE: Students may not transport medication, unless physician has completed written order to carry epinephrine autoinjector or inhaler**

**Parent Signature:**_____**Date:** _____**phone:**_____

### TO BE COMPLETED BY PRINCIPAL/ ASSISTANT PRINCIPAL:

**PRINCIPAL/ASSISTANT PRINCIPAL APPROVAL:** _____

**SIGNATURES OF PERSONS AUTHORIZED TO GIVE MEDICATION:**

_____ _____ _____