ALVARADO ISD OPERATIONS DEPARTMENT

PO Box 387 ♦ 110 South Bill Jackson Drive
Alvarado, TX 76009
Phone: (817) 783-6807
Fax: (817) 783-6892

FOOD ALLERGY MANAGEMENT PLAN

Identification

Upon registration the parent will be provided a copy of the Request for "Food Allergy Information" Form to provide them with an opportunity to disclose whether their child has a food allergy as required by TEC 25.0022. If the parent indicates that the child has a food allergy on their form, they will be given a copy of the "Parent Letter Requesting Medical Statement" form with instructions on how they can assist the school in developing an Individualized Health Care Plan for their child. The parents will also be given a copy of the "Child Nutrition Medical Statement Form" and the "Allergy Health Care Action Plan" form. These two forms must be completed by a licensed physician.

The "Child Nutrition Medical Statement" form is for children who require substitutions or modifications to school meals because of the restrictions associated with their disability.

The "Allergy Health Care Action Plan" form is designed 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 the "Child Nutrition Medical Statement" form, 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 "Child Nutrition Medical Statement" form will be placed in the cafeteria.

The "Allergy Health Care Action Plan" will be given to the school nurse.

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.

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Parent Letter Requesting Medical Statement

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 "Medical Statement" form. This form is for children who require substitutions or modifications to school meals because of the restrictions associated with their disability. In order for the district to provide a meal accommodation for a student with a medical disability, the parent or guardian must provide a medical statement signed by medical authority who is licensed by the State of Texas to write prescriptions. Any medical authority whose prescription is allowed to be filled by a pharmacy located in Texas under Texas law and regulation may provide a medical statement for a meal accommodation.

The medical statement must include the following information in order for the district to make the meal accommodation:

1. Statement explaining the student's medical disability which includes a description that is sufficient to allow the school to understand how this condition restricts the student's diet
2. Description of the accommodation to be made: food items or ingredients to be omitted, food items ingredients to be substituted, modified food texture, and/or other accommodation. If the medical statement requires substitutions, the medical statement should include a list of food or beverage items that are appropriate substitutions. Also note, a school is not required to provide a name brand product if another product with the same specifications is available.

If the licensed medical authority does not provide a medical statement that includes the information listed above, the school cannot make a meal accommodation.

If the medical statement is unclear or lacks sufficient detail, the school must request appropriate clarification so that a proper and safe meal can be provided. When clarification is provided, any changes to the medical statement must be provided in writing before the school implements the changes.

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,

Abigail Treviño
Child Nutrition Director

Revised January 2024

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Child Nutrition Medical Statement

(To Provide Information for a School to Make an Appropriate Meal Accommodation)

This form may be (1) used by a licensed medical authority to provide a medical statement for a student's medical disability or a special dietary need that warrants a meal accommodation or (2) used to assist a licensed medical authority in creating the medical statement necessary for a meal accommodation. If this form is used as a medical statement, the form must be completed by the medical authority and signed by both the parent and the medical authority. The reverse side of this form provides additional information on the regulations related to school meal accommodations.

I. Provide the following information about the student.

Student Name: ____________________ Date: __________

Student Birthdate: __________ Student's Grade Level: ______

Does the student have a medical disability which affects one of the major life functions which necessitates a meal accommodation? ☐ Yes ☐ No

Does the student have a special dietary need that will be helped by a meal accommodation? ☐ Yes ☐ No

II. How does this medical disability or special dietary need impact the student's diet?

III. What meal accommodation(s) are appropriate to address the student's medical disability or special dietary needs? Please check the box before applicable meal accommodations and provide a detailed explanation for each checked accommodation in the box beside the description.

☐ Food items or ingredients not to be served

☐ Suggested substitutions for food items not served

☐ Specific information on portion sizes for food items

☐ Specific description of texture modifications for specific food types or items

☐ Special utensils

☐ Other

IV. Provide the following signatures.

Parent Signature ____________________ Date __________

Medical Authority Signature ____________________

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Information on Accommodations to School Meals for Students with a Medical Disability

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) must provide reasonable accommodations for students with medical disabilities.

> *The Code of Federal Regulations (7 CFR, Part 15b) defines a person with a disability as (1) having a physical or mental impairment that substantially limits one or more major life activities and (2) having a record or is regarded as having a physical or mental impairment.*

Schools may also provide accommodations for special medical or dietary needs that restrict a student's diet but are not considered a medical disability.

For an NSLP or SBP site to provide a meal accommodation for a student with a medical disability, the parent or guardian must provide a medical statement signed by medical authority who is licensed by the State to write prescriptions. For this purpose, State is defined as the State of Texas. Any medical authority whose prescription is allowed to be filled by a pharmacy located in Texas under Texas law and regulation may provide a medical statement for a meal accommodation.

The medical statement must include the following information in order for the CE to make the meal accommodation:

1. Statement explaining the student's medical disability which includes a description that is sufficient to allow the school to understand how this condition restricts the student's diet
2. Description of the accommodation to be made: food items or ingredients to be omitted, food items ingredients to be substituted, modified food texture, and/or other accommodation

   If the medical statement requires substitutions, the medical statement should include a list of food or beverage items that are appropriate substitutions. Also note, a school is not required to provide a name brand product if another product with the same specifications is available.

If the licensed medical authority does not provide a medical statement that includes the information listed above, the school cannot make a meal accommodation.

When a school believes the medical statement is unclear or lacks sufficient detail, the school must request appropriate clarification so that a proper and safe meal can be provided. When clarification is provided, any changes to the medical statement must be provided in writing before the school implements the changes.

AISD HEALTH SERVICES

Severe Allergic Reaction or Anaphylaxis Emergency Action Plan

Student: ____ DOB: ________________ Grade: ______________

Parent/Guardian: ____ Phone: ______________________

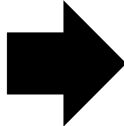
Allergy to: ____

Reaction: ____

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

ANY SEVERE SYMPTOMS AFTER SUSPECTED OR KNOWN INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body or (combination) hives, itchy rashes, swelling
GUT: Vomiting, diarrhea, cramping, pain

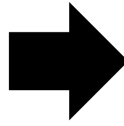


1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
3. Consider giving additional medications following epinephrine:
   - Antihistamine
   - Inhaler, if wheezing

*Do Not Rely on antihistamines or inhalers to treat an anaphylactic/severe reaction – USE EPINEPHRINE!!

MILD SYMPTOMS ONLY:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort
Nose: Itchy/runny nose, sneezing



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. Watch closely for changes. If symptoms worsen, give EPINEPHRINE
4. Begin monitoring (see below)

Monitoring: 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 of anaphylaxis do not resolve with initial dose of epinephrine and EMS arrival will exceed 5 to 10 minutes, a second dose of epinephrine may be administered.

Healthcare Provider

Epinephrine (brand & dose): ____

Antihistamine (brand & dose): ____

Other (e.g., inhaler/bronchodilator): ____

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

☐ YES ☐ NO Student has been instructed in the proper way to administer their emergency medication and may self-carry. Student is knowledgeable about this medication and has the skills to safely possess and use the prescribed medication.

Name ______________________________ Phone (___) _____- _______ Signature ____________________________ Date __________

Parent/Guardian

☐ YES ☐ NO I give permission for the medicine(s) listed above to be administered by the nurse or other school staff as appropriate.

☐ YES ☐ NO I request that the above named student, be allowed to carry his/her Epinephrine prescribed above. I accept the legal responsibility should the medication be lost, given, or taken by a person other than the student for whom it was prescribed. If this should happen, the privilege of carrying the epinephrine may be revoked. I understand that AISD has no legal responsibility when the above named student administers his/her own medication.

☐ YES ☐ NO I consent to communication between the prescribing health care provider or clinic and the school nurse necessary for allergy management and administration of this medicine.

Name ______________________________ Phone (___) _____- _______ Signature ____________________________ Date __________

AISD Health Services

Severe Allergic Reaction or Anaphylaxis Emergency Action Plan

School Nurse

☐ YES ☐ NO The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name ________________________________ Signature ______________________________ Date ___________________

TRAINED STAFF MEMBERS

Name: ____ Date: ____________________

Name: ____ Date: ____________________

Name: ____ Date: ____________________

LOCATION OF MEDICATION

- Student to carry ____
- Health Office/Designated Area for Medication: ______________________________
- Other: ____

EPIPEN (EPINEPHRINE) AUTO-INJECTOR:

1. Remove the EpiPen Auto-Injector from the plastic carrying case
2. Pull off the blue safety release cap
3. Swing and firmly push orange tip against mid-outer thigh
4. Hold for approximately 10 seconds
5. Remove and massage the area for 10 seconds

AUVI-Q (EPINEPHRINE INJECTION, USP):

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions
2. Pull off red safety guard
3. Place black end against mid-outer thigh
4. Press firmly and hold for 5 seconds
5. Remove from thigh

ADRENACLICK/ADRENACLICK GENERIC:

1. Remove the outer case
2. Remove gray caps labeled “1” and “2”
3. Place red rounded tip against mid-outer thigh
4. Press down hard until needle penetrates
5. Hold for 10 seconds. Remove from thigh