Flow Chart for Management of Student with Food Allergies At-Risk Anaphylaxis

Conduct case finding to identify students with food allergies or a history of anaphylaxis from sources including:

- Student/Family
- Student Health History Form
- Health Record/Medical Records
- Student Information Form
- School Staff

↓

Nurses will send to parent of student with food allergy or history of anaphylaxis:

- Letter to Parents Requesting Additional Documentation
- **Parent Letter**
- **Dietary Request Form**
- Specialized Health Care Procedure Form
- Food Allergy Action Plan /Emergency Action Plan

↓

Nurse Meets with Cafeteria Manager Provides copy of Completed Dietary Request Form" to Cafeteria Manager and provides copy to Dietician:

Nurse Will Document and Record Student Health History Data on:

- Allergy Alerts on Focus
- Health Alerts on Focus

Nurse collaborates with Cafeteria Manager, Parent/Student/Principal/Teacher/Physician/ Dietician to Develop the Individualized Healthcare Plan for students who require emergency medication for allergy exposure.

↓

Principal Designates Staff to be Trained

By school nurse

To care for students with Food Allergies/Anaphylaxis

↓

Nurse Provides Training for:

- Classroom Teacher
- Principal Designated Staff
- Bus Drivers
- Food Service Personnel
- Other School Staff as needed

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Dear Parent,

Our records indicate that your child ______________________________ has a potentially severe allergy that may require treatment at school. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the forms, listed below, that will give us the necessarey information and authorization to treat your child in an emergency.

1. Dietary Request Form (Parent Letter)
2. Dietary Request Form
3. Specialized Health Care Procedure Form – Physician
4. Specialized Health Care Procedure Form – Parent
5. Food Allergy Action Plan (FAAP / Emergency Action Plan (EAP)

It is important for your child's safety that we have the proper authorizations and supplies on hand in order to respond in an emergency. We appreciate your help in our effort to provide the best care for your child.

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

Sincerely,

School Nurse
Attachments

DISTRITO ESCOLAR INDEPENDIENTE DE FORT WORTH

Departamento de Servicios de Salud

Estimados Padres,

Nuestros archivos indican que su niño(a) ______________________________ tiene una alergia que potencialmente puede ser severa y requiera tratamiento en la escuela. El Distrito Escolar requiere información adicional para poder tomar precauciones necesarias para la seguridad de su niño(a) y autorizar tratamiento para su niño(a) en caso de que tenga una reacción alérgica en la escuela u otra actividad relacionada con la escuela.

Esta carta incluye las formas, enumeradas abajo, que nos brindarán la información y autorización necesarias para poder administrar tratamiento a su niño(a) en caso de una emergencia.

1. Petición Para Cambios O Modificación En La Dieta (Carta para los padres)
2. Petición Para Cambios O Modificación En La Dieta
3. Forma de Tratamiento de Salud Especializado para Padres
4. Forma de Tratamiento de Salud Especializado para el Medico
5. Plan de Acción de Alergia a Alimentos (FAAP) / Plan de Acción en Emergencia (EAP)

Por la seguridad de su niño(a) es muy importante que tengamos la autorización y materiales disponibles para poder actuar en una emergencia. Apreciamos su ayuda en nuestro esfuerzo de proveer el mejor cuidado para su niño(a).

Por favor pida a su doctor u otro proveedor de salud licenciado que llene estas formas y entréguelas a la enfermera escolar lo más pronto posible.

Atentamente,

Enfermera
Archivo Adjunto

Fort Worth ISD Child Nutrition Services Dietary / Allergy Request Form

1559466938

Return completed form to the school nurse

1. Parent/Guardian: complete Section A. Sign and date form (required for processing)
2. Medical Authority: complete Section B. Print, sign and date form (required for processing)
3. Return completed form to the school nurse
4. Dietitians will review and process dietary requests in the order in which they are received
5. Incomplete form will be returned to the school nurse for parent/guardian completion

- Nutrition, carbohydrate content, and allergen information is available via MealViewer to help you plan your child's meals in a way that fits with your dietary and religious preferences, no dietary request form is needed. MealViewer can be accessed here: https://schools.mealviewer.com/district/FortWorthISD OR users can download the MealViewer To Go App available for Apple and Android devices.

SECTION A. To be Completed by Parent/Guardian

Student ID Number | **Student's Name (Last, First)** | **Date of Birth**

Request Type
☐ New ☐ Change/Modify ☐ Discontinue

Which meals provided by the School Cafeteria will the student eat?
☐ Breakfast ☐ Lunch ☐ NONE

Does the student have an identified disability? (IEP or 504 Plan)?
☐ IEP ☐ 504 ☐ No

Parent/Guardian Email Address (CLEARLY PRINT)

Parent Requests that are not due to a medical disability. Please Note: Nutrition Services may attempt to accommodate cultural/personal preferences but are NOT required by law to do so. These accommodations depend on product availability on the daily serving line. ☐ **Vegan** ☐ **Vegetarian** ☐ **No Pork** ☐ **No Beef** ☐ **Other**

Section B will not be required for requests not due to a medical disability.

This form must be completed at the start of each school year and any time there is a change or discontinuation of dietary needs during the school year. Annual completion of this form by the student's medical authority ensures that current nutritional needs are being communicated.
I give Fort Worth ISD Child Nutrition Services permission to speak with the medical authority to discuss dietary needs as ordered.

X
PARENT/GUARDIAN SIGNATURE **Date** **Phone number of Parent/Guardian**

SECTION B. To be Completed by Physician/Medical Authority

TEXTURE MODIFICATION:

☐ Year Round ☐ Temporary: Start: ______ Stop: ______

Special Utensils required: ______

Specific Nutritional Needs: (carbs, calories, etc.): ______

Liquids: ☐ Thin (Reqular liquids) ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

Solids: ☐ Regular ☐ Soft & Bite-Sized ☐ Minced & Moist ☐ Pureed

ALLERGIES (Select all that apply):

EGG
☐ Whole eggs such as scrambled eggs or hard cooked eggs
☐ Baked goods with any egg listed as an ingredient

DAIRY
☐ All food/beverages with milk listed as an ingredient including baked goods
☐ Cheese and recipes with cheese listed as an ingredient
☐ Yogurt
☐ Fluid Milk (Substitution: ☐ Lactose-free milk ☐ Water ☐ Soy)

FISH OR SHELLFISH
☐ Fish
☐ Shellfish

WHEAT / GLUTEN
☐ Recipes with wheat listed as an ingredient
☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

CORN
☐ Whole corn such as corn kernels, tortilla chips, corn muffin
☐ Recipes with corn / corn products listed as an ingredient

NUTS
☐ Peanuts
☐ Tree Nuts specify: ______

SOY
☐ Soy Lecithin
☐ Soy Protein (concentrate, hydrolyzed, isolate)
☐ Menu items with any soy listed as an ingredient

OTHER ______

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Name of Medical Authority: ______ (PLEASE PRINT) ☐ MD ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP

Prescribing Physician/Medical Authority Signature: ______ (SIGNATURE) ______ (DATE)

Phone Number: ______

School Nurse/Office Personnel USE ONLY

Manager's Name: ______ Manager's Email: ______ Phone Number: ______ School Name & Number: ______

School RN Name: ______ School RN Phone Number: ______ School RN Email: ______

Fort Worth ISD Servicios de Nutrición Infantil
Formulario sobre Información de Dieta y Declaración de Alergías
Devuelva la forma completada a la enfermera de la escuela

Fort Worth INDEPENDENT SCHOOL DISTRICT

6291351973

1. Padre/Guardián: complete Sección A. Firme y escriba la fecha (requerido para procesar)
2. Autoridad médica: complete Sección B. Nombre impreso, firma y la fecha (requerido para procesar)
3. Devuelva el formulario completo a la enfermera de la escuela.
4. Dietistas revisarán y procesarán sus formularios de acuerdo al orden en que son recibidos.
5. Todo formulario incompleto será devuelto a la enfermera de la escuela para que lo complete el Padre o Guardián.

- La información sobre nutrición, contenido de carbohidratos e alérgenos está disponible a través de MealViewer para ayudarlos a planificar las comidas de su hijo de manera que se ajuste a sus preferencias dietéticas y religiosas, no se necesita un formulario de solicitud de dieta. Se puede acceder a la aplicación MealViewer a través de: https://schools.mealviewer.com/district/FortWorthISD. También pueden descargar la aplicación MealViewer To Go disponible para dispositivos Apple y Android.

SECCIÓN A. Para ser Completo por el Padre / Guardián

Número de Identificación del Estudiante | **Nombre del Estudiante (Apellido, Primer Nombre)** | **Fecha de Nacimiento**

Tipo de Solicitud ☐ Nueva ☐ Cambiar/Modificar ☐ Descontinuar

¿Qué comidas proporcionadas por la Cafetería de la Escuela comerá el estudiante? ☐ Desayuno ☐ Almuerzo ☐ NINGUNO

¿Tiene el estudiante una discapacidad identificada? (IEP o Plan 504)? ☐ IEP ☐ 504 ☐ No

Dirección de correo electrónico del Padre/Guardián (ESCRIBE LEGIBLE)

Solicitudes de los padres que no se deben a una discapacidad médica. Tenga en cuenta: Los Servicios de Nutrición pueden intentar acomodar preferencias culturales / personales, pero NO están obligados por ley a hacerlo. Estas adaptaciones dependen de la disponibilidad del producto en la línea de servicio diario.

☐ **Vegano** ☐ **Sin Cerdo** ☐ **Otros**
☐ **Vegetariano** ☐ **Sin Carne**

Seccion B no será requerida para solicitudes que no se deban a discapacidad médica.

Este formulario debe completarse al comienzo de cada año escolar y cada vez que haya un cambio o interrupción de las necesidades dietéticas durante el año escolar. La finalización anual de este formulario por parte de la autoridad médica del estudiante garantiza que se comuniquen las necesidades nutricionales actuales.

Doy permiso a los Servicios de Nutrición Infantil del Distrito Escolar Independiente de Fort Worth para hablar con la autoridad médica para discutir las necesidades dietéticas según lo ordenado.

X

FIRMA DEL PADRE/GUARDIÁN | **Fecha** | **Número de Teléfono del Padre/Guardián**

SECCIÓN B. Para ser Completo por el Médico Primario / Autoridad Médica

MODIFICACIÓN DE TEXTURA:

☐ Todo el Año ☐ Temporal Comienzo: __________ Termina: __________

Requiere Utensilios Especiales: ______________________

Nutrientes Especificos: Carbohidratos, calorías, si aplica:

Líquidos: ☐ Delgado (Líquidos Regulares) ☐ Ligeramente Grueso ☐ Moderadamente grueso ☐ Extremadamente grueso

Sólidos: ☐ Regular ☐ Picado y Húmedo ☐ Suave y de Tamaño de Bocado ☐ Puré

ALERGIAS (Seleccione todas las que apliquen):

HUEVO
- ☐ Huevos enteros como huevos revueltos o huevos cocidos.
- ☐ Productos horneados con cualquier huevo listado como ingrediente

LÁCTEOS
- ☐ Todos los alimentos / bebidas con leche incluida como ingrediente, incluidos los productos horneados
- ☐ Queso y recetas con queso listado como ingrediente
- ☐ Yogur
- ☐ Leche fluida (Sustitución: ☐ Leche Sin Lactosa ☐ Agua ☐ Soya)

PESCADO O MARISCO
- ☐ Pescado
- ☐ Marisco

TRIGO / GLUTEN
- ☐ Recetas con trigo listado como ingrediente
- ☐ Recetas con gluten (trigo, cebada, centeno, triticale) listadas como ingrediente

MAÍZ
- ☐ Maíz entero como granos de maíz, chips de tortilla, muffin de maíz
- ☐ Recetas con maíz / productos de maíz listados como ingrediente

NUECES
- ☐ Maní (Cacahuate)
- ☐ Nueces de Árbol (especifique):______________________

SOYA
- ☐ Lecitina de Soya
- ☐ Proteína de soya (concentrado, hidrolizado, aislado)
- ☐ Artículos del menú con cualquier soya listada como ingrediente

OTROS ______________________

Certifico que al estudiante mencionado anteriormente se le deben ofrecer sustituciones de alimentos como se describió anteriormente debido a la alergia alimentaria o la intolerancia / alergia alimentaria del estudiante según la discapacidad.

Nombre de la Autoridad Médica: ______________________ (ESCRIBA EN LETRA DE MOLDE) ☐ MD ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP

Firma del médico / autoridad médica que prescribe: ______________________ (FIRMA) ______________ (FECHA)

Número de Teléfono: ______________________

No escriba aquí abajo. Para uso Escolar Solamente

FARE
Food Allergy Research & Education

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: ______________________________

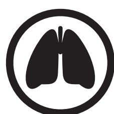
THEREFORE:

☐ 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:

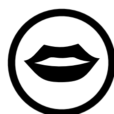
SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

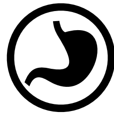
HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

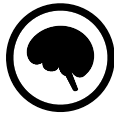


MOUTH
Significant swelling of the tongue or lips

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.

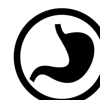
- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms 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: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

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

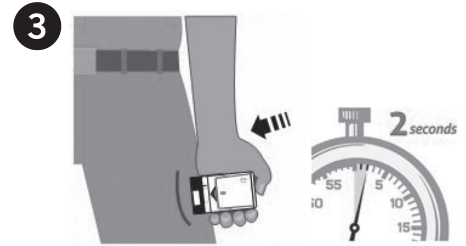
____

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

FARE
Food Allergy Research & Education

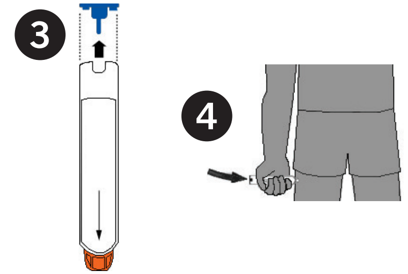
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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



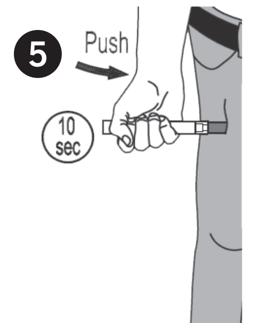
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

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