



***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

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No**PLACE
PICTURE
HERE****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

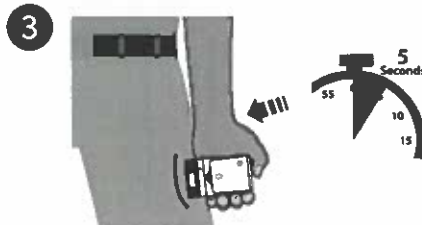
DATE

**FARE**

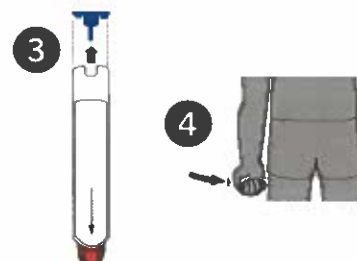
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO**

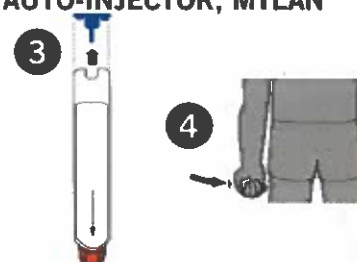
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

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

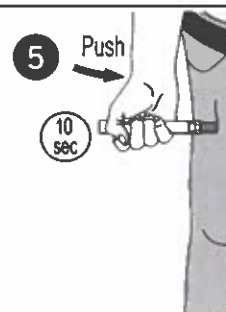
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the 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 ADRENALCLICK®), 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: _____

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 a State licensed healthcare professional or registered dietitian (e.g. MD, DO, NP, APRN, or RD) All sections must be filled out for meal modifications to be implemented.		
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 consent to LTISD FANS contacting your child's medical provider about the listed condition. To opt out, initial here: _____		
<i>I have read the above orders and agree with this plan of care for my child.</i>		
_____ Parent Signature		_____ Date

Submit completed forms to your campus nurse or email them to Food and Nutrition Services. Please allow up to 7 business days for processing. Parents may remove restrictions with written consent by emailing the FANS Dietitian at bellm@ltsdschools.org. To add or update accommodations, a new form must be submitted.

For more information, visit: www.ltsdschools.org/mealaccommodations.

Updated: 07/22/25



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

- ☐ Medical History
- ☐ Physician's Orders
- ☐ On-going Communication

Purpose of Disclosure

Develop an appropriate health care plan

To clarify student's medical needs

School Nurse

at: _____
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