Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

School Medication Administration Authorization Form

This order is valid only for school year (current)_____, including summer session.

School:_____

This form must be completed fully in order for school to administer the required medication.
A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- ★ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ★ Non-prescription (over the counter) medication must be in the original container with the label intact. Students' names and date of birth must be on the medication.
- ★ Over the counter medications, except topical creams/ointments, require physician signature.
- ★ An adult must bring the medication to school. Any controlled substance must be counted with the parent and a staff member.
- ★ If a controlled substance is permitted for self carry, only the daily dose(s) needed are allowed to be carried.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade:_____

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____ Route:_____

Time/frequency of administration:_____ If PRN(as needed), frequency:_____

If PRN(as needed), for what symptoms: _____

Special administration instructions:_____

Relevant side effects: ▫ None Expected ▫ Specify:_____

Special storage requirements: ▫ None ▫ Refrigerate ▫ Other:_____

Medication Shall be administered from:(Month/day/year):_____ to _____

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

Prescriber's Signature:_____

Date:_____

Parent/Guardian Authorization

I/We request school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication. I/We authorize the school personnel to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date:_____

Home/Cell Phone #:_____ Work Phone #:_____

Self Carry/Self Administration of Medication Authorization/Approval

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and parent.

This student may carry this medication: ▫ Yes ▫ No

This student is both capable and responsible for self-administering this medication:

▫ Yes, supervised ▫ Yes, unsupervised ▫ No

Prescriber's authorization for self carry/self administration of medication: _____
Signature/Date

Parent's approval for self carry/self administration of medication:_____
Signature/Date

Special Diet Statement

Why am I being asked to fill out this form?
Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.* According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors are not required to accommodate special dietary requests that are not a disability. This includes requests related to religious or moral convictions or personal preference. **If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.**

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. **Updates to this form are required only when a participant's needs change.**

Parents/Guardians may provide a written request for lactose-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: **Anne Merchant** annemerchant@wlcsd.org

Participant Information:

Participant's Full Name: _____ Today's Date: _____

Date of Birth: _____

Name of School Attended: _____

Parent/Guardian Name: _____

Work/Cell Phone Number: _____

Required Information: Dietary Accommodation

1. List the food to be avoided:

_____

2. Briefly explain how exposure to this food affects the participant:

_____

3. List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

*School Nutrition Program –7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4). 4

Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print):_____ Date: _____

Signature: _____Clinic/Hospital:_____

Phone Number: _____ Fax Number:_____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to **Walled Lake Consolidated Schools Food Service Department** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional:** My permission to release this information will expire on _____ **(date).** This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian: _____ Date:_____

OR Participant's Signature (Adult Day Care ONLY):_____

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

LHSA
A Community Action Agency

EARLY HEAD START/HEAD START
ALLERGY/PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent/Guardian:

You have indicated on your child's emergency card or health history that your child has allergies. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child's allergies? Yes ____ No ____

2. Which of the following is your child allergic to? Please list.
   Foods _____
   Environmental (trees, pollen, etc.) _____
   Animals _____
   Medications _____
   Other _____

3. What happens to your child during an allergic reaction? _____
   _____

4. Does your child need special care during an allergic reaction? Yes ____ No ____
   If yes, what care does your child need? _____

5. Is your child currently taking medications for allergies? Yes ____ No ____
   If yes, please list all medications. _____

6. Does your child need medication at school for treatment of allergies? Yes ___ No ___

****If your child needs medical attention or medication for an allergic reaction while at school, you and your child's physician must complete and sign an ALLERGY ACTION PLAN.**

7. Is there anything else we need to know about your child's allergies? _____
   _____

8. Parent/Guardian Signature _____Date: _____

Thank you for your cooperation.

_____ _____ _____
Head Start/Early Head Start Staff Phone # Date

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OLHSA

A Community Action Agency

OLHSA EARLY HEAD START/HEAD START
Medication Parent Consent Form

All prescription medicine must be in the original pharmacy container, clearly labeled with the child's name, physician's name, date and instructions for administering medication. To protect your child and others, please **do not leave** any medication in your child's belongings, cubby, locker or classroom. Medication must be personally delivered to a Head Start/Early Head Start staff member.

I agree to hold OLHSA Head Start/Early Head Start and its staff free from any liability in the event of allergic reaction or mishap occurring as a result of medication being administered to my child at my request and according to the instructions provided by a physician, at the center or field trip.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____