

### Food Allergy Assessment Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell/work: \_\_\_\_\_

Health Care Provider (name) treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you think your child's food allergy may be life-threatening?  No  Yes  
(If YES, please see the school nurse as soon as possible).

Did your student's health care provider tell you the food allergy may be life-threatening?  No  Yes  
(If YES, please see the school nurse as soon as possible.)

#### History and Current Status

Check the foods that have caused an allergic reaction:

- |   |   |                               |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts              | <input type="checkbox"/> Fish/shellfish                             | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products                               | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils   | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) |                               |

Please list any others: \_\_\_\_\_

How many times has your student had a reaction?  Never  Once  More than once, explain: \_\_\_\_\_

When was the last reaction? \_\_\_\_\_

Are the food allergy reactions:  staying the same  getting worse  getting better

#### Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? (Check all that apply)

- Eating foods  Touching foods  Smelling foods  Other, please explain: \_\_\_\_\_

What are the signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say.)

How quickly do the signs and symptoms appear after exposure to the food(s)?

\_\_\_\_ Seconds    \_\_\_\_ Minutes    \_\_\_\_ Hours    \_\_\_\_ Days

#### Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

- No  Yes, explain: \_\_\_\_\_

Does your student understand how to avoid foods that cause allergic reactions?  Yes  No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment?  No  Yes

Does your student know how to use the treatment?  No  Yes

Please describe any side effects or problems your child had in using the suggested treatment: \_\_\_\_\_

**If you intend for your child to eat school provided meals, have you filled out a diet order form for school?**

Yes.

No, I need to get the form, have it completed by our health care provider, and return it to school.

**If medication is to be available at school, have you filled out a medication form for school?**

Yes.

No, I need to get the form, have it completed by our health care provider, and return it to school.

**If medication is needed at school, have you brought the medication/treatment supplies to school?**

Yes.

No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods? \_\_\_\_\_

**I give consent to share, with the classroom, that my child has a life-threatening food allergy.**

Yes.

No.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by R.N.: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Health Care Provider,

The state of Washington has published \*guidelines for care of students with life-threatening allergies. The guidelines are comprehensive; however, the message to alert health care providers who prescribe emergency medications to be given at school to students who had a contact with an allergen is:

**For students with a medical order to administer epinephrine at school to treat anaphylaxis or possible anaphylaxis, the recommended protocol after exposure is to immediately:**

- 1. Administer Epinephrine**
- 2. Call 911**
- 3. Call Parents**

**Benadryl can no longer be administered first and there cannot be a “wait and watch” period of time. This change is necessary because:**

1. Most schools do not have full time nurses in the building. Even if the nurse is in the district, it is impossible for the nurse to be on location at all times to provide an *accurate assessment of the student’s health status*.
2. Unlicensed school staff (health clerks, secretaries, principals, teachers, coaches, bus drivers, etc.) will be the front line adults on site when the student has a contact to the specific allergen causing potential anaphylaxis.
3. **Unlicensed school staff members are unprepared to assess the student’s health status to determine whether or not to administer epinephrine and/or when to administer it. *Registered nurses may not delegate assessment and clinical judgment to unlicensed school staff.***
4. For the safety of the student, epinephrine will be administered immediately as ordered by the health care provider.

Thank you for your assistance in implementing this requirement.

If you have any questions, please contact the school nurse.

\**Guidelines for Care of Students with Anaphylaxis* available at <http://www.k12.wa.us/HealthServices/Publications/09-0009.aspx>



# DIET PRESCRIPTION FOR MEALS AT SCHOOL



Federal law and USDA regulation require school nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include food allergies and digestive conditions, but does not include personal diet preferences. Requests must be medically necessary.

### SECTION A: TO BE COMPLETED BY PARENT OR GUARDIAN:

Student Name: \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

1. My student will bring **ALL** meals from home.  YES  NO  
(Meals from home are the safest option.)

• I understand that by answering YES to #1 above, Child Nutrition Services will not provide ANY meals for my student under any circumstances.

2. My student will receive all meals from school.  YES  NO  Breakfast  Lunch

3. My student will receive meals from home and school.  BOTH (Will notify School Kitchen each time a student isn't eating a meal)

- I understand that if my child's medical or health needs change, it is my responsibility to obtain a **NEW Diet Prescription for Meals at School** form and submit it to the health room at my student's school.
- I understand that if my child no longer requires a special diet, it is my responsibility to obtain documentation from my student's health care provider in order to liberalize my student's diet at school.
- I give Child Nutrition Services and the School Nurse permission to discuss my student's dietary needs with the health care provider listed below.

\_\_\_\_\_  
PRINT Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Primary Telephone #

**IF YOU ANSWERED YES TO QUESTION #1 ABOVE, STOP! THE FORM IS COMPLETE.**

### SECTION B: TO BE COMPLETED AND SIGNED BY A STATE RECOGNIZED MEDICAL AUTHORITY (RMA)

\*State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Washington: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA) with prescriptive authority, Naturopathic Physician, Advanced Registered Nurse Practitioner (ARNP) or Registered Dietitian Nutritionist (RD/RDN).

1. Describe how the ingestion/contact with the food affects the student: Dx: \_\_\_\_\_

Life-Threatening Food Allergy  Non-Life Threatening Food Allergy  Celiac Disease  Food Intolerance

2. Explain what must be done to modify the student's diet (i.e. Foods to be omitted/avoided in the student's diet).  
Check all that apply:

Fluid Cow's Milk  All Dairy  Wheat/Gluten  Soy  Peanuts  Tree Nuts  Eggs  Fish  Shellfish  Sesame

Other: \_\_\_\_\_

**Foods to Substitute:**  No substitutions necessary

Standard substitutions offered in our district are acceptable (Please see back of this form)

Suggested general substitutions: \_\_\_\_\_

*I certify that the above named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.*

**Recognized Medical Authority Including Credentials:**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax

#### FOR OFFICE USE ONLY:

Received by Nurse: \_\_\_\_\_ / \_\_\_\_\_  
Date Initial

Received by Child Nutrition Office: \_\_\_\_\_ / \_\_\_\_\_  
Date Initial

Received by Kitchen Manager: \_\_\_\_\_ / \_\_\_\_\_  
Date Initial

| <b>STANDARD FOOD SUBSTITUTIONS FORM</b>  |   |   |
|--|---|---|
| <p>Below are standard substitutions for common allergies and food intolerances. By signing Section B, the standard food substitutions are accepted unless the "No Substitutions necessary" is selected. Substitutions are limited to those items commonly available from Nutrition Services.</p>   |   |   |
| <b>PEANUTS</b>   |   | <b>TREE NUTS</b>  |
| <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Cheese Sandwich</li> <li>• Yogurt</li> <li>• Deli Meat Sandwich</li> <li>• Cheese Stick</li> <li>• Beef, Chicken, Pork, Dairy proteins</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>  |   | <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Cheese Sandwich</li> <li>• Yogurt</li> <li>• Deli Meat Sandwich</li> <li>• Cheese Stick</li> <li>• Beef, Chicken, Pork, Dairy proteins</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>   |
| <b>DAIRY</b> (Note: No foods containing any part of dairy)   |   | <b>SOY</b> (Note: Many of our food items contain soy)   |
| <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Beef, Chicken, Pork</li> <li>• Deli Meat Sandwich</li> <li>• Tortilla/Corn Chips</li> <li>• Oatmeal</li> <li>• Rice/Corn Cereal</li> <li>• Bread Products without any form of milk protein.</li> <li>• Hummus, seeds, non-animal proteins</li> </ul> |   | <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Yogurt, String Cheese</li> <li>• Corn Chip</li> <li>• Oats/Oatmeal,</li> <li>• Rice Rice/Corn Cereal</li> <li>• Soy free hamburger, cheeseburger, chicken</li> <li>• Deli Meat</li> <li>• Hummus, seeds, non-animal proteins</li> </ul> |
| <b>WHEAT/GLUTEN INTOLERANCE</b>  |   | <b>FISH</b>   |
| <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Gluten Free Bread/Buns</li> <li>• Rice</li> <li>• Hard Taco Shell</li> <li>• Tortilla/Corn/Potato Chips</li> <li>• Oatmeal</li> <li>• Rice/Corn Cereal</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>                                      |   | <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Cheese Sandwich</li> <li>• Deli Meat Sandwich</li> <li>• Beef, Chicken, Pork, Dairy proteins</li> <li>• Yogurt</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>   |
| <b>EGG</b>   |   | <b>SESAME</b>   |
| <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Beef, Chicken, Pork, Dairy proteins</li> <li>• Cheese Sandwich</li> <li>• Deli Meat Sandwich</li> <li>• Cereal</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>  |   | <b>School Substitutions Could Include:</b> <ul style="list-style-type: none"> <li>• Cheese Sandwich</li> <li>• Yogurt</li> <li>• Deli Meat Sandwich</li> <li>• Cheese Stick</li> <li>• Beef, Chicken, Pork, Dairy proteins</li> <li>• Hummus, seeds, non-animal proteins</li> </ul>   |
| <b>FOR FLUID MILK SUBSTITUTIONS ONLY</b>   |   |   |
| <b>MILK ALLERGY</b>  | <b>LACTOSE INTOLERANCE</b>  | <b>SOY &amp; MILK</b>   |
| <b>School Substitution:</b> <ul style="list-style-type: none"> <li>• Soy Milk</li> </ul>   | <b>School Substitution:</b> <ul style="list-style-type: none"> <li>• Lactose-Free Milk or Soy Milk</li> </ul> | <b>School Substitution:</b> <ul style="list-style-type: none"> <li>• Soy &amp; Dairy-Free Option or Juice</li> </ul>  |



## Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

|   |  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
|---|--|---|---|---|---|------|------|-------------------------|--------------------|-------------|--|--------------------|-------------|
| <b>Student</b>  | Student Name: _____ Birth Date: _____<br>_____   |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Released By</b>  | I authorize:<br>This/these entity(ies) (name/address of recipient(s)):<br>Attention: _____<br>Address: _____<br>Phone: _____<br>To use and/or disclose a copy of the health/service information described below for the above named student  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Released To</b>  | I authorize:<br>This/these entity(ies) (name/address of recipient(s)):<br>Attention: _____<br>Address: _____<br>Phone: _____<br>To use and/or disclose a copy of the health/service information described below for the above named student  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Purpose</b>  | For the purpose(s) of:<br><input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations.<br><input type="checkbox"/> Other purposes (specify each purpose): _____<br>_____  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Information to be Disclosed</b>  | Description or nature of information to be used and/or disclosed: (check all that apply)<br><input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports<br><input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report<br><input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____<br><table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> <b>Mental Health</b><br/> <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> N/A         </td> <td style="padding: 5px;">           My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.         </td> </tr> <tr> <td style="padding: 5px;"> <b>Substance Use</b><br/> <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> N/A         </td> <td style="padding: 5px;">           My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.         </td> </tr> </table>   | <b>Mental Health</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. | <b>Substance Use</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. |      |      |                         |                    |             |  |                    |             |
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| <b>Notices</b>  | I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Expiration</b>   | I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.<br><br>Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period:<br><br>Date: _____   |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| <b>Signatures</b>   | I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age.<br><br><table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 60%; border-bottom: 1px solid black; text-align: center;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; padding: 5px;">Update of Authorization</td> <td style="width: 40%; padding: 5px;">Signature 1: _____</td> <td style="width: 35%; padding: 5px;">Date: _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">Signature 2: _____</td> <td style="padding: 5px;">Date: _____</td> </tr> </table> | Signature of student  | Date  | Signature of legal/personal representative  | Relationship to student   | Date | Date | Update of Authorization | Signature 1: _____ | Date: _____ |  | Signature 2: _____ | Date: _____ |
| Signature of student  | Date   |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| Signature of legal/personal representative  | Relationship to student  |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| Date  | Date   |   |   |   |   |      |      |                         |                    |             |  |                    |             |
| Update of Authorization   | Signature 1: _____   | Date: _____   |   |   |   |      |      |                         |                    |             |  |                    |             |
|   | Signature 2: _____   | Date: _____   |   |   |   |      |      |                         |                    |             |  |                    |             |