Bellevue School District CELIAC Individual Health Plan

Name:	_____	Birth Date:	_____	
School:	_____	Grade	_____	

Celiac Disease: Celiac disease is an immune reaction to eating gluten, a protein found in wheat, barley, spelt, oat, and rye, which requires strict avoidance.

DATE OF PREVIOUS REACTION:	_____	**PREVIOUS SYMPTOMS (If applicable):** ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Bloating ☐ Vomiting ☐ Rash ☐ Fatigue ☐ Other: _____

EMERGENCY CARE PLAN

POSSIBLE CELIAC SYMPTOMS



IF YOU SUSPECT AN STUDENT HAS INGESTED GLUTEN OR COME INTO CONTACT WITH GLUTEN, CONTACT PARENT

**In accordance with RCW 18.79.040, if a registered nurse is on site, they may utilize the nursing process, which includes assessment, specialized knowledge, judgment, and skill in determining plan of care or treatment.*

MEDICATION/TREATMENT ORDERS: *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM. IHP can be filled out by School Nurse based on BSD "Medication Authorization Form – 3416P Exhibit A" or other completed provider orders.*

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Licensed Health Care Provider's signature: _____ ***Signature authorizes medication for length of school year***	**Date:**	_____	**Phone:**	_____
	School year:	_____	**Fax:**	_____

PARENT/GUARDIAN/STUDENT (age 18 and older) RESPONSIBILITIES:

- I will notify the school nurse of any changes in health status or healthcare provider instructions.
- If my student attends extended day/childcare, clubs before- and after-school, evening, and summer activities, I will notify the program director of my student's medication and health care needs.

I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of any injury resulting from reasonable and prudent administration of medication, the reasonable performance of health care procedures, or the liabilities arising out of self-administration and self-carrying of medication by my student/me. BSD staff have been trained to assist with medication administration.

I accept this Individual Health Plan. *My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.*

Parent/Guardian/Student (age 18) signature: _____	**Date:**	_____	**Phone:**	_____
				_____

INDIVIDUAL CONSIDERATIONS:

Cafeteria:

- **Elementary School (P-5th grade):** Parent may request the option for their child to eat in an allergen-aware area in the lunchroom.
- **Middle/High School (6th-12th grade)**: Student will be making his/her own decision regarding food and seating choices.

Classroom:

- Teacher to inform substitute teachers of the student's Individual Health Plan
- Teachers will notify parent/guardian of classroom food celebrations
- **Elementary School**: Student should not be given food at school unless it is first approved by the parent/guardian
- Store bought, packaged food with clear ingredient list is strongly encouraged for use in food celebrations
- Teachers will notify parent/guardian of instructional materials or classroom projects which contain possible allergens

Field Trip Procedures: Students who self-carry are responsible for their own medication. Medication and IHP will accompany student during any off-campus activity.

School Nurse: Will notify teachers, other school staff, transportation, and nutrition services of student's IHP

Please return to:

School Nurse: _____	**Email:**	_____@bsd405.org	**Phone:**	425-456-_____
			Fax:	425-456-_____

Updated 2/23/26

See also BSD Policy/Procedures: 2410 Student Health; 3418 Emergency Treatment
Other Resources: https://celiac.org/