OCEAN VIEW SCHOOL DISTRICT
Educational Support Services/Health Services
714-847-2551 ext. 1314 ◆ 714-596-7078 FAX

Questionnaire for Parents of Child with Food Allergy/Sensitivity

Please print:

School Year: _____ Date: _____

Student Name: _____ Birth Date: _____ Grade: _____

Parent Name: _____ Home #: _____ Work #: _____

Physician Name: _____ Telephone: _____

You have notified the school that your child has food allergy/sensitivity. The following information will be helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer to the best of your ability and return this form to the school office. Thank you!

Nurse's Name: _____ Telephone: _____

1. Allergic to: _____
2. Approximate date of last reaction: _____
3. Description of reaction: _____
4. Was your child treated by a doctor or hospital for this? Yes ❑ No ❑
5. Was medication prescribed by a doctor? Yes ❑ No ❑

   If yes, name of medication(s): _____ Dosage: _____

   _____ Dosage: _____

Parent Signature: _____ Date: _____

If your doctor has recommended medication be given immediately in case of an allergic reaction, a supply of medication can be kept and given at school for emergency use. If you wish to arrange for this, please contact the school nurse.

OCEAN VIEW SCHOOL DISTRICT
Student Services/Health Services
Severe Allergy Action Plan

Student Name_____ DOB_____ Date_____

Allergy to: _____ Does the student have **Asthma**? ❑ Yes ❑No

STEP 1: TREATMENT

(Following to be determined by the provider authorizing treatment)

Symptoms	**Give Checked Medication**	
• 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† - Thready pulse, low blood pressure, fainting, pale, blueness	❑ Epinephrine	❑ Antihistamine

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

Dosage

- **Epinephrine**: inject intramuscularly ❑EpiPen® ❑EpiPen® Jr. ❑Other: _____
- **Antihistamine**: give (*name, dose, route*)_____
- **Other**: give (*name, dose, route*)_____

STEP 2: EMERGENCY CALLS

1. Call 9-1-1. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parent/Guardian Name_____ Phone number _____
3. Parent/Guardian Name_____ Phone number _____

Authorized Health Care Provider Signature _____ Authorized Health Care Provider (printed)_____ Telephone _____Date_____	*Office Stamp*
Parent Signature: _____ Date: _____ School Nurse Signature:_____ Date: _____	

Revised 09/2025

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Name of Student:_____ Birth date:_____ Grade/Track: _____

School/District:_____ Teachers Name: _____

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that the following treatment(s) be administered to my child as ordered by the authorized health care provider:
Emergency Treatment of Allergic Reactions and Anaphylactic Shock
I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new authorization form if there are ANY changes in the treatment and/or prescribing authorized health care provider. I give permission for the school nurse to exchange treatment related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the treatment and its possible reactions.

Parent/Guardian Signature:_____ Date: _____

Telephone: (Work)_____ (Home)_____ (Other) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Treatment: Emergency Treatment of Allergic Reactions and Anaphylactic Shock

Time schedule and/or indication: _____

Precautions, possible untoward reactions, and recommend intervention(s): _____

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed as checked below:

( ) a. Implement the treatment using nursing practice standards along with the following modifications:

( ) b. Implement the treatment using nursing practice standards along with my attached recommendations.

Authorized Health Care Provider Signature:_____

Provider NPI#:_____

Telephone: _____

Date of Request: _____

Date to Discontinue Treatment: _____

Office Stamp

SCHOOL USE:
Reviewed by:_____ Date: _____

This request is valid for a maximum of one year.

Revised: 8/18 PK

EMERGENCY TREATMENT OF ALLERGIC REACTIONS AND ANAPHYLACTIC SHOCK

ALLERGEN
Please Specify

_____

I. GENERAL INFORMATION

To recognize and relieve symptoms of allergic reactions.

A. Purpose: To recognize and relieve symptoms of allergic reactions.

B. Average allergic reaction is a hypersensitive state to a foreign substance (allergen), such as insect sting venom, certain foods, chemicals or drugs.

B. Reactions may range from mild to life-threatening anaphylactic shock. Delayed reactions, such as joint pain, achiness, and localized redness and warmth may occur a few days later.

C. Signs and symptoms may include:

Mild	Moderate/Severe	Anaphylactic Shock
Localized: Pain	Generalized, intense itching	Agitation
Itching	Dizziness	Difficulty breathing --
Swelling	Headache	(Swelling of the throat)
Redness	Nausea	Cyanosis
	Hives	Throbbing heart beat
	Abdominal cramps	Convulsions
		Unconsciousness

D. Anaphylactic shock is serious and can be fatal. It may occur within 5 minutes to 1 hour after exposure to the allergen. Emergency action is imperative to prevent severe complications or death.

E. Since injections are involved in the management of anaphylactic shock, the adoption of a policy of giving injections by personnel other than nurses is left to the discretion of each school district or county office. A pre-filled, auto-injection method (such as Epipen) is recommended for ease of administration.

F. Parent/care provider to supply necessary equipment for performing procedure at school.

II. PERSONNEL

A. School Nurse

B. Designated school personnel under direct or indirect supervision by the school nurse.

EMERGENCY TREATMENT OF ALLERGIC REACTIONS AND ANAPHYLACTIC SHOCK

Student's Name:_____ DOB:_____

Equipment and Supplies *(Responsibility of parent/care-provider).	1. Oral and/or topical medications as prescribed by physician (Chlortrimeton, Benedryl, etc.) 2. * Emergency injection kit (Adrenalin/Epinephrine)	3. For insect stings/bites, add the following: • Antiseptic solution • Meat tenderizer, baking soda • Cold pack

PROCEDURE

ESSENTIAL STEPS	KEY POINTS & PRECAUTIONS
1. Notify school nurse immediately.	
2. Determine severity of allergic reaction and proceed accordingly: For insect sting/bite, continue with Step #3; for all other allergic reactions, proceed DIRECTLY TO STEP #4, 5, or 6, depending on severity.	
Manage insect sting/bite If stinger is still in skin, scrap off with fingernail, fingernail file or tongue blade. DO NOT SQUEEZE STINGER.	Stinger may have venom sac attached. Squeezing may release more venom.
a. Cleanse sting area with antiseptic solution and rinse well with cold water.	Cleansing reduces chances of secondary infection.
b. Apply meat tenderizer or baking soda.	Venom contains protein elements that are broken down by meat tenderizer. Baking soda acts as a neutralizer.
c. Apply cold pack to sting area.	Cold reduces swelling. Wrap cold pack in toweling, Since direct application of ice can cause tissue damage.
3. Manage Mild Reaction a. Apply cold pack, if appropriate.	Cold reduces swelling. Wrap cold pack in toweling, since direct application of ice can cause tissue damage.
ESSENTIAL STEPS	**KEY P0INTS & PRECAUTIONS**

b. Observe student for 20 – 25 minutes. 1) If localized pain and itching subside or remain minimal, student may return to class. 2) If localized pain, itching and swelling increase, notify parent/care-provider. 3) If moderate or severe symptoms, or anaphylactic shock develops, continue as per procedure.	
3. Manage Moderate/Severe Reactions: a. If intense itching with hives occurs <u>without</u> progression to anaphylactic shock symptoms, then give oral/ topical medication if prescribed by physician. This may be sufficient. b. Notify physician and parent/care-provider.	
4. Manage **Anaphylactic Shock** a. Administer oral medication if prescribed by physician. b. Administer intramuscular injectable medication immediately straight into the upper, outer thigh or top of arm. c. Call paramedics and notify parent/ care-provider. d. Cover with blanket to maintain body temperature.	Be prepared to administer adrenalin, as <u>seconds</u> count!
5. Document incident.	**If at any time during procedure breathing stops - INITIATE CPR IMMEDIATELY.** These are large muscle groups commonly used for deep injections.

Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____

School/District: _____ Teachers Name: _____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: epinephrine( ) Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____Maximum number of doses

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____Date: _____

This request is valid for a maximum of one year.

Revised 10-3-2018 pk

Orange County Department of Education
Community and Student Support Services

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

Name of Student: _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 10-3-2018 pk

Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____

School/District: _____ Teachers Name: _____ Grade/Track: _____

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Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: antihistamine(_____)Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____Maximum number of doses

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

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SCHOOL USE:

Reviewed by: _____Date: _____

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Revised 10-3-2018 pk

Orange County Department of Education
Community and Student Support Services

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NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 10-3-2018 pk

Medical Statement to Request Special Meals and/or Accommodations

Medical Statement Form		
1. School	**2. Site Name**	**3. Site Phone Number**
4. Name of Child		**5. Age or Date of Birth**
6. Name of Parent/Guardian		**7. Phone Number**
8. Description of Child's Physical or Mental Impairment Affected:		
9. Explanation of Diet Prescription and/or Accommodation:		
10. Indicate Food Texture for Above Child: ☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**		
11. Adaptive Equipment to be Used:		
12. Foods to be Omitted and Appropriate Substitutions:		
Foods to Be Omitted	**Suggested Substitutions**	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
13. Signature of Registered Dietitian (RD) or State Licensed Healthcare Professional*		
14. Printed Name	**15. Phone Number**	**16. Date**

*In California, effective April 1, 2025, RDs are permitted to complete and sign a written medical statement for school meal modifications due to a disability. The CDE also permits the following state licensed healthcare professionals to complete and sign a written medical statement for a disability: licensed physicians, physician assistants, and nurse practitioners.

*This form is also considered valid with a certified digital signature.

The information on this form is required to reflect the current medical and/or nutritional needs of the child.

Instructions

1. **School**: Print the name of the school that is providing the form to the parent/guardian.

2. **Site**: Print the name of the site where meals will be served.

3. **Site Phone Number**: Print the phone number of site where meal will be served.

4. **Name of Child**: Print the name of the child to whom the information pertains.

5. **Age of Child**: Print the age of the child. For infants, please use date of birth.

6. **Name of Parent/Guardian**: Print the name of the person requesting the child's medical statement.

7. **Phone Number**: Print the phone number of parent/guardian.

8. **Description of Child's Physical or Mental Impairment Affected**: Describe how the physical or mental impairment restricts the child's diet.

9. **Explanation of Diet Prescription and/or Accommodation**: Describe a specific diet or accommodation that has been prescribed by the RD or state licensed healthcare professional.

10. **Indicate Texture**: If the child does not need any modification, check "Regular".

11. **Adaptive Equipment to be Used**: Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheelchair accessible furniture, etc.).

12. **Foods to be Omitted**: List specific foods that must be omitted.
    Suggested Substitutions: List specific foods to include in the diet.

13. **Signature of RD or State Licensed Healthcare Professional**: Signature of RD or statelicensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name**: Print name of RD or state licensed healthcare professional.

15. **Phone Number**: Phone number of RD or state licensed healthcare professional.

16. **Date**: Date RD or state licensed healthcare professional signed the form.

Definitions

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes*,* the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;

2. fax: 202-690-7442; or

3. email: Program.Intake@usda.gov.

This institution is an equal opportunity provider.