

Pine Grove Area School District

SCHOOL HEALTH SERVICES
2026-2027 School Year
Food Allergy Emergency Action Plan

Name of Student

Date of Birth

Medical Problems

Food Allergies

Medication Allergies

Step 1: Treatment

Symptoms	Give checked medication			
If a food allergen has been ingested, but no symptoms	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Mouth (itching, tingling, swelling of lips/tongue/mouth)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Skin (hives, itching, rash, swelling of face/extremities)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Gut (nausea, abdominal cramps, vomiting, diarrhea)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Throat (tightness, hoarseness, hacking cough)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Lung (shortness of breath, coughing, wheezing)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Heart (weak/thready pulse, low blood pressure, fainting, pale)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
If reaction is progressing (several of the above areas affected)	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Other _____ _____	☐ EpiPen IM	☐ Diphenhydramine 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____

Step 2: Emergency Calls

- 1) If EpiPen is given or other medications are not effective, call 911 for ambulance transport.
- 2) Contact Parent/Guardian as listed on Student Update form (copy attached).

Physician's Signature

Date

Physician's Name Printed

Physician's Phone Number

Signature of Parent/Guardian

Date



Pine Grove Area School District



SCHOOL HEALTH SERVICES

2026-2027 School Year

Medication Order

It is this school district's policy to request that medications be given before or after school hours. When this is not possible, prior to receiving the medication (prescription or non-prescription) at school, each student must provide the school nurse with a Medication Order signed by a licensed prescriber and the student's parent/guardian. All medications must be in the original container. This form is valid only for the current school year.

Name of Student

Date of Birth

Medical Problems

Allergies

Name of Medication

Dosage

Route

Diagnosis / Reason for Taking

Frequency / Time of Administration

Discontinuation Date

Specific Directions

☐ Student may carry and self-administer EpiPen

☐ Student may carry and self-administer inhaler

Additional Information (Serious reactions, side effects, contraindications, etc.)

Other Medications Currently Taking

Licensed Prescriber's Signature

Date

Licensed Prescriber's Name Printed

Licensed Prescriber's Phone Number

I give permission for the above medication to be given to my child during school hours. I understand that the medication will be given according to my child's licensed prescriber's directions. I do hereby release, discharge, and hold harmless the Pine Grove Area School District, its agents and its employees from any and all liability and claim whatsoever for the administration of the above medication to the above named child.

Signature of Parent/Guardian

Date

Pine Grove Area School District

SCHOOL HEALTH SERVICES

2026-2027 School Year
Epi-Pen Contract

Name of Student

Date of Birth

I give permission for my child to carry and administer their Epi-Pen. Thus, the school is not responsible for ensuring the medication is taken. The school district and its employees are relieved of any responsibility for the benefits or consequences of the Epi-Pen.

Signature of Parent/Guardian

Date

I have received and understand the instructions from my physician/CRNP/PA on proper safety precautions for the handling and disposal of my Epi-Pen and agree to abide by the following rules:

I will follow the directions for the use of my Epi-Pen as ordered by my physician/CRNP/PA.

I will never allow another student to have access to my Epi-Pen.

I will notify the school nurse each time I use my Epi-Pen.

I understand that if I do not follow these rules, I will lose the privilege to carry my Epi-Pen.

Signature of Student

Date

The above named student has demonstrated the ability to correctly self-administer his/her prescribed Epi-Pen.

Signature of School Nurse

Date

Pine Grove Area School District

SCHOOL HEALTH SERVICES

2026-2027 School Year
Asthma Inhaler Contract

Name of Student

Date of Birth

I give permission for my child to carry and administer their inhaler. Thus, the school is not responsible for ensuring the medication is taken. The school district and its employees are relieved of any responsibility for the benefits or consequences of the inhaler.

Signature of Parent/Guardian

Date

I have received and understand the instructions from my physician/CRNP/PA on proper safety precautions for the handling and disposal of my inhaler and agree to abide by the following rules:

I will follow the directions for the use of my inhaler as ordered by my physician/CRNP/PA.

I will never allow another student to have access to my inhaler.

I will notify the school nurse each time I use my inhaler.

I understand that if I do not follow these rules, I will lose the privilege to carry my inhaler.

Signature of Student

Date

The above named student has demonstrated the ability to correctly self-administer his/her prescribed asthma inhaler.

Signature of School Nurse

Date

Children with Disabilities and Special Dietary Needs

Schools participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school meals because of a disability that restricts the diet.

1. Licensed Medical Authority's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at [7 CFR Part 15b](#) require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for School Food Service") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs

School food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests, including those related to general health concerns, personal preferences, and moral or religious convictions, are not disabilities and are optional for school food authorities to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008*, a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

4. Individuals with Disabilities Education Act

A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that school food service staff is involved early in decisions regarding special meals. If an IEP or 504 plan includes the same information that is required on a medical statement (see section 1, above), then it is not necessary to get a separate medical statement.

School Nutrition Program Contact

For more information about requesting accommodations to school meals and the meal service for students with disabilities, contact:

Click here to enter local contact name and information.

Mr. Bernie Kelly / 570-345-2731 (ext. 357) / bkelly@pgasd.com

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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** program.intake@usda.gov.

This institution is an equal opportunity provider.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Contact your child's school.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Comuníquese con la escuela de su niño.

Medical Plan of Care for School Food Service

Please read pages 1 and 2 before completing this form.

Student's Name	Date of Birth	Grade Level/Classroom
Name of School/Site		
Name of Parent/Guardian	Phone Number of Parent/Guardian	
Signature of Parent/Guardian	Date	
1. Provide an explanation below of how the student's physical or mental impairment restricts the student's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: ☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other:		
5. List any required special adaptive equipment:		
Name of Physician/Medical Authority & Title (Please Print)		Provider Phone Number
Signature of Physician/Medical Authority		Date
<p><i>Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.</i></p> <p>Health Insurance Portability and Accountability Act Waiver In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school 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 my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.</p> <p>The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.</p> <p>Parent/Guardian Signature: _____ Date: _____</p>		