LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Letter Requesting Additional Documentation For Student Identified As Having A Severe Food Allergy

Dear Parent or Guardian:

You have disclosed that _____ has a severe food allergy. The District requires additional information in order to take necessary precautions for the student's safety and to authorize treatment of the student in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Food Allergy & Anaphylaxis Emergency Care Plan ("FARE" form)*;
2. LTISD Food and Nutrition Services Food Allergy/Intolerance Notification*;
3. Self-Carry/Administration of Medication Authorization*;
4. Request for Medication Administration; and
5. Release/Consent to Request Medical Information.

Forms noted with an asterisk must be completed and signed by an MD, DO, NP, or APRN. Please return these forms to your school nurse as soon as possible. Any additional information or documentation that will help assist the campus in recognizing the signs and symptoms of an anaphylactic reaction that your student might experience is also greatly appreciated.

Sincerely,

LTISD Student Health Services

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

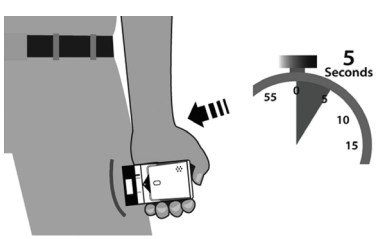
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

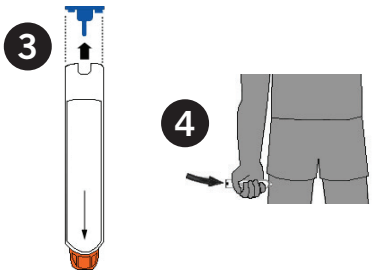
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



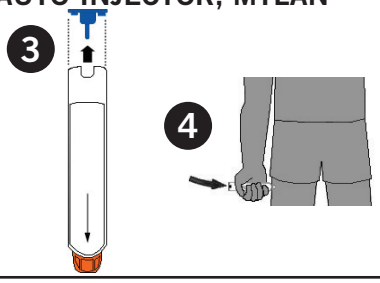
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



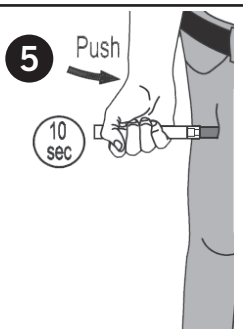
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

Lake Travis ISD Food and Nutrition Services

Medical Meal Accommodations

This form is not required to be updated annually unless there is an update to your student's medical condition.

Part A: to be completed by parent/guardian	
Student Name: _____	**DOB:** _____ **Student ID:** _____ **Campus:** _____ **Grade:** _____
Printed Parent/Guardian Name: _____	**Phone Number:** _____ **Email Address:** _____

Part B: MUST be completed by a State licensed healthcare professional or registered dietitian (e.g. MD, DO, NP, APRN, or RD) All sections must be filled out for meal modifications to be implemented.

1. Does the child have a disability recognized by the Americans with Disabilities Act?

❑ Yes ❑ No

2. If the child does NOT have a disability, does the child have a food allergy or intolerance that results in an anaphylactic or adverse reaction when exposed to that specific food?

❑ Yes ❑ No

3. Please identify the disability, food allergy, or intolerance & describe the major life activities affected.

4. Check all foods that affect the child (if applicable):

❑ **Fresh Dairy** (fluid milk, yogurt, cheese, cheese powder, etc.) ❑ **Baked Dairy** (baked/cooked into another food item)

❑ **Fresh Eggs** (scrambled eggs, mayonnaise, dressings, etc.) ❑ **Baked Eggs** (baked/cooked into another food item)

❑ **Peanuts** ❑ **Tree Nuts** ❑ **Wheat/Gluten** ❑ **Soy** ❑ **Fish** ❑ **Shellfish** ❑ **Sesame**

❑ Other:_____

5. Please describe meal accommodation to be made: (foods to be omitted, modified, or substituted)

_____	_____	_____
Physician's Printed Name or Stamp	**Physician's Signature**	**Date**

By submitting this form, you consent to LTISD FANS contacting your child's medical provider about the listed condition. To opt out, initial here: _____.

I have read the above orders and agree with this plan of care for my child.

_____	_____
Parent Signature	**Date**

Submit completed forms to your campus nurse or email them to Food and Nutrition Services. *Please allow up to 7 business days for processing.Parents may remove restrictions with written consent by emailing the FANS Dietitian at bellm@ltisdschools.org. To add or update accommodations, a new form must be submitted.*
For more information, visit: www.ltisdschools.org/mealaccommodations.

Updated: 07/19/26

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Self-Carry/Administration of Medication Authorization

A responsible, trained student is permitted to carry and/or self-administer medication on his/her person for immediate use in a life-threatening situation with a written order from a physician/prescribing health care provider, parent/guardian request, and school nurse and principal approvals.

Student: _____ Grade: _____ Date of Birth: _____

Condition for which medication is administered: _____

Name of medication: _____ Dose: _____

Method of administration for medication: _____

Timing /Indication for administration of medication: _____

Side effects to be noted/reported: _____

Other recommendations:_____

Dates of administration: From _____ to _____ (not to exceed one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician: _____ Telephone(s): _____

Physician's Signature: _____ Date: _____

Parent/Guardian Authorization

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, the medication name, date of the original prescription, strength and dosage of the medication, and directions for use. No more than a 30 day supply of the medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or the end of the medical order.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Principal/School Nurse Approvals

We accept the parent request and physician statement above. We will permit/assist the student to be responsible with this self-carry medication, but reserve the right to withdraw the privilege if student shows signs of irresponsibility, or if there is a reported safety risk. In the event that a safety risk has been determined, the administration will contact parent/guardian as soon as possible.

School Nurse's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: □ by mouth □ via inhaler □ topical (cream) □ injection □ other _____

Condition for which medication is given: _____

To be given: □ Entire School Year - or - □ The following dates: ___ /___ /____ to: ___ /___ /____

When: □ At the following time(s): _____ - or - □ As needed every _____ hours Special

considerations/side effects: _____

For Daily Medications: _____ Yes, please send on field trips
_____ No, please do not send on field trips

Other medications taken at home: _____
List any food or drug allergies: _____

Must be signed by a physician for any of these reasons:

□ prescription given more than 10 school days (daily medication)
□ any over-the-counter medication

Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.

Signature:	Date:
Printed Name:	Phone:

Physician: I request that the student receive this medication during the school day as instructed above.

Signature:	Date:
Printed Name:	Phone:

School: Medication was received by:

Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date:

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Release/Consent to Request Medical Information

Student Name _____

Date of Birth _____ **Grade** _____ **Campus** _____

Please authorize the person named below to request specified records containing confidential information regarding the above-named student.

From: Lake Travis Independent School District

To: _____
Physician to whom the request is made

_____
Campus

_____
Phone number

_____
Address

_____
Address

_____
City/State/Zip

_____
City/State/Zip

_____
Fax

_____
Fax

Records to be released

□ Medical History
□ Physician's Orders
□ On-going Communication

Purpose of Disclosure

Develop an appropriate health care plan

To clarify student's medical needs

_____ at: _____
School Nurse Phone Number

□ Yes □ No I have been fully informed and understand the school's request for my consent, as described above. This information will be requested upon receipt of my written consent.

□ Yes □ No I understand that my consent is voluntary and may be revoked at any time.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name