

Protocol for Students with Special Dietary Needs

1. Anyone made aware of food issues will notify the District Nurse
2. When Blue Emergency Forms are received with food issues noted the Health Services Team will:
 - a. Notify District Nurse ASAP
 - b. Mail out a Physician's Diet Modification Form w/cover letter and a Food Allergy & Anaphylaxis Emergency Care Plan form, if the allergy needs to be documented. (Required each year)
 - c. Email the information to their campus cafeteria manager and the Director of Child Nutrition. In the subject line they will include **FOOD ALLERGY NOTIFICATION**. This is to be in ALL CAPS. A call should be made as well.
3. The District Nurse will:
 - a. Review any medical information provided
 - b. Put information into TXeis, noting DOCUMENTED OR UNDOCUMENTED
 - c. Once documentation has been received, notify the campus counselor of the need to 504 the student or update their existing plan
 - d. Assist with development of a 504 plan with counselor
4. The Child Nutrition Director will:
 - a. Place an alert on the student's meal account
 - b. Provide additional information/training to the Child Nutrition Staff as needed
 - c. Assist with development of a 504 plan with counselor
 - d. Provide a hard-copy of alerts to be used at the point-of-sale in case of a power outage
 - e. Distribute master product lists to their staff for cross-referencing allergens
5. The Counselor will:
 - a. Assist with 504 meeting and plan formation
 - b. Follow protocols for 504 interventions
6. COCISD will:
 - a. Modify undocumented food allergies for up to 30 calendar days to give a parent time to get the Documentation for students new to our district
 - B. Carry over documented food allergies from the previous school year for 30 calendar days into the New school year, to give parents time to secure new orders from their doctor

Managing Students with Special Dietary Needs

Dear Parent/Guardian,

You are receiving this information because you listed a special dietary need on your child's emergency form.

USDA regulations (7 CFR Part 15b) require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions at school when that need is **supported by a statement signed by a licensed physician**. A severe food allergy that causes anaphylaxis is defined as a disability.

The attached **Physician's Diet Modification form** will need to be completed and returned by _____. After this date, all modifications will stop unless proper documentation is received. All information must be complete and readable. This information must be updated yearly. For your convenience, we have also included an Anaphylaxis Emergency Care Plan that your physician can use to order emergency care for life-threatening food allergies.

Mail to: Attn. Becky Smith R.N. - P.O. Box 39- Coldspring Texas 77331

Fax to: Attn. Becky Smith R.N. - (936) 653-3689

Email to: rsmith@cocisd.org

If you have any questions, please feel free to contact:

Becky Smith, R.N.
Director of Health and Wellness
936-653-1185 or 1150

We greatly appreciate your prompt attention to this matter.

Sincerely,

Becky Smith, RN

Becky Smith, RN
Health Services Director
Coldspring-Oakhurst CISD

PHYSICIAN'S DIET MODIFICATION FORM

Student Name _____ Student ID # _____ Date of Birth _____
Grade _____ Parent/Guardian _____ Telephone(____) _____

As parent or guardian, I give permission for COC ISD to contact the Physician's office regarding my child's dietary needs. _____ (Parent Signature)

The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for any diet modification or substitution to be made in school meals. This form must be signed by a licensed physician.

Physician's Statement

LIFE THREATENING FOOD ALLERGY – Omit these foods:

_____ Fluid Milk (by itself) _____ Milk (as an ingredient) _____ Peanuts _____ Tree nuts _____ Eggs
_____ Fish _____ Shellfish _____ Wheat _____ Soy _____ Other: _____

OTHER DISABLING DIAGNOSES REQUIRING DIETARY MODIFICATION:

1. Can the student consume foods where the allergen is an ingredient in the food product? ____ yes ____ no
Example: Any foods that contain eggs or milk are unacceptable.)
Explain _____

2. Explanation of why this disability restricts diet: _____

3. Major life activity affected by the life threatening food allergy or disability (check all that apply):
(NOTE: COCISD cannot honor this document unless at least one life activity is marked.)

_____ eating _____ caring for one's self _____ performing manual tasks _____ walking _____ seeing
_____ hearing _____ speaking _____ breathing _____ learning

4. Foods to Substitute (NOTE: COCISD cannot honor this document unless substitutions are listed below.)

Physician's Signature _____ Date _____

Physician's Name _____

Telephone(____) _____ Clinic/Facility Name _____

RETURN TO DIRECTOR OF HEALTH SERVICES

Questions? Contact the District Nurse 936-653-1150 FAX 936-653-5137

According to the Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

**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**Short of breath,
wheezing,
repetitive cough**HEART**Pale, blue,
faint, weak
pulse, dizzy**THROAT**Tight, hoarse,
trouble
breathing/
swallowing**MOUTH**Significant
swelling of the
tongue and/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/runny
nose,
sneezing**MOUTH**

Itchy mouth

**SKIN**A few hives,
mild itch**GUT**Mild nausea/
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

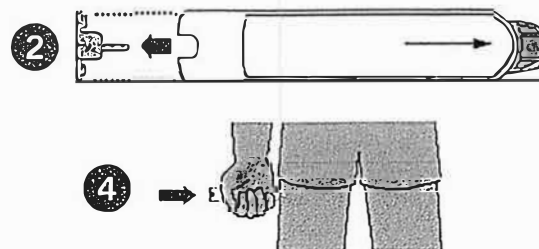
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

EpiPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENALINE® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



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

EMERGENCY SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____