Greensburg Salem School District

SEVERE FOOD ALLERGY

Dear Parent/Guardian:

Name _____

Your child's medical history indicates that he/she has a severe food allergy. Because of the potential seriousness of this allergy, we would like to know specifically what foods your child is allergic to and how your child reacts to these foods. Please complete this form and return it to the school nurse.

PLEASE LIST THE FOODS YOUR CHILD IS ALLERGIC TO:

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE CHECK THE SYMPTOM(S) YOUR CHILD EXPERIENCES:

❒ Nausea/vomiting ❒ Hives ❒ Shortness of breath/difficulty swallowing

❒ Anaphylactic reaction ❒ Other _____

TREATMENT REQUIRED:

❒ Call home immediately ❒ Administer Epipen ❒ Call Ambulance

❒ Oral Medication

❒ YES ❒ NO

If Yes: Medication Name _____ Dosage _____

NOTE: If medication is to be administered in school for a severe allergy reaction, please have your physician complete the information below and return this entire form to the school. A parent note must accompany medication as well. Medication must be sent to school with proper labeling

Type of reaction: _____

Medication: _____

Dosage: _____

Route of Administration: _____

If Epipen is to be administered, please give specific instructions: _____

_____

Physician Signature: _____ Date: _____

HEALTH CARE PLAN FOR FOOD ALLERGIES

Date_____

Student_____

Food Allergy_____

_____

Symptoms of an allergic reaction_____

_____

Treatment_____

_____

Epipen expiration date_____

Degree of Sensitivity

Ingestion only_____ Any Contact (air/ touch)_____

ADAPTATIONS

Separate Cafeteria table _____
No snacks with manufacturer disclaimer_____

Classroom snack restrictions

Parents will provide all treats_____

May have safe prepackaged treats_____

No home baked treats_____

Special considerations_____

_____

Physician's Name_____
Phone:_____

Parent Signature_____
Phone:_____

Medical Plan of Care for School Food Service

for students with special dietary needs

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **recognized medical authority** (licensed physician, physician assistant, certified registered nurse practitioner, or dentist). Food allergies that may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (licensed physician, physician assistant, certified registered nurse practitioner, or dentist).
- The school may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as lactose intolerance or for cultural or religious beliefs. If available, the milk substitutes must meet nutrient standards identified in federal regulations and will be indicated in Part 2. A milk substitution may be requested by a medical authority or a parent/guardian. If this is the only substitution being requested, complete Parts 1 and 2 only.

Part 1: Student Information - *Completed by Parent/Guardian*

Child's Name	Date of Birth	M F
Name of School/Center/Program	Grade Level/Classroom	
Parent's/Guardian's Name	Address, City, State, Zip Code	
Daytime Phone ( )		
Evening Phone ( )		

Part 2: Request for Fluid Milk Substitution *only* (for non-disabled students) – *Completed by Parent/Guardian or Recognized Medical Authority*

☐ School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.

☐ School/school district provides _____ as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes ☐ No ☐
List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

Medical Authority or Parent/Guardian Signature:_____ **Date:**_____

Part 3: Request for Modifications/Substitutions for Special Dietary Needs – *Completed and signed by Recognized Medical Authority (licensed physician, physician assistant, certified registered nurse practitioner, or dentist), including phone number and stamp of office name and address.*

Does the child have a **disability**? Yes ☐ No ☐

If Yes,
Please describe the major life activities affected by the disability:

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐
(*These accommodations are *optional* for schools to make)

Diet Order:

List any dietary restrictions, such as food allergies, intolerances or restrictions:

List specific foods to be substituted (***Substitution cannot be made unless section is completed***):
List foods that need the following changes in texture. If all foods need to be prepared in this manner, indicate "All." Cut up/chopped into bite sized pieces: Finely Ground: Pureed:
List any special equipment or utensils needed:
Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number	**Office Stamp**
Physician/Medical Authority's Signature	**Date**

Part 4:

Parent Signature	**Date**

Part 5:

School Nutrition Program Signature	**Date**

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.

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.

Parent/Guardian Signature:_____ **Date:**_____

(Signing this section is optional, but may prevent delays by allowing us to speak with the physician/medical authority)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ____ Date _____ ____ Date _____ ____ Date_____

____ Date_____ ____ Date _____ ____ Date _____ ____ Date _____ ____ Date_____

A copy of this form should be kept by the School Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.

GREENSBURG SALEM SCHOOL DISTRICT

SERIES 400 - STUDENTS **CODE: 400.49.1**

STUDENT POSSESSION AND USE OF EPI PENS

The Greensburg Salem School District shall permit students to possess EPI Pens (epinephrine auto-injectors) and to self-administer the prescribed medication to treat anaphylaxis when such possession and use prescribed by a physician and is parent-authorized.

Possession and use of EPI Pens by students shall be in accordance with the laws of the Commonwealth of Pennsylvania and Board policy as herein outlined.

Definitions

EPI Pen shall mean a prescribed device used for self-administration of epinephrine for the emergency treatment of severe allergic reactions (anaphylaxis) caused by allergens, exercise, or unknown triggers. EPI Pens are designed for use immediately in an emergency situation and to give the student time to get to a hospital or medical center. EPI Pens are not a substitute for emergency medical treatment.

Self-administration shall mean a student's use of the medication in accordance with a prescription or written instructions from a physician, certified registered nurse practitioner or a physician assistant.

Guidelines

Before a student may possess or use an EPI Pen during school hours or at a school-sponsored event, the District will require the following:

- A written request from the parent/guardian that the District complies with the order of the physician, certified registered nurse practitioner, or physician assistant prescribing an EPI Pen and its use for their son/daughter.
- A statement from the parent/guardian acknowledging that the District is not responsible for ensuring the medication is taken and relieving the District and its employees of responsibility for the benefits or consequences of the prescribed medication.

- A written statement from the physician, certified nurse practitioner or physician assistant that states:
  - The name of the drug/medication.
  - The prescribed dosage.
  - The times the medication is to be taken.
  - The length of time the medication is prescribed.
  - The diagnosis or reason the medication is needed.
  - Potential serious reactions or side effects of the medication.
  - The appropriate emergency response.
  - The student is qualified and able to self-administer the medication.

- The student shall be made aware by a school nurse that the EPI Pen is intended solely for his/her use only and may not be shared with other students.

- The student must notify the school nurse, or in her absence, a building administrator, immediately following each use of an EPI Pen.

- Violations of this policy by a student shall result in immediate confiscation of the EPI Pen and loss of privileges. Violations may also be considered as violations of the District's Medication Policy and Drug and Alcohol Policy.

A student whose parent/guardian completes the written requirements for the student to possess an EPI Pen and self-administer the prescribed medication in the school setting shall demonstrate to the school nurse the capability for self-administration and responsible behavior in the use of medication.

To self-administer medication:

1. Identify his/her medication and the symptoms indicating the need to administer the medication.
2. Demonstrate the proper technique for self-administering medication.
3. Demonstrate an understanding of policy requirements regarding self-administration.

The District reserves the right to require a statement from the physician, certified registered nurse practitioner or physician assistant for the continued use of a medication beyond the specified time period.

Permission for possession and use of an EPI Pen by a student will be effective for the school year for which it is granted and must be renewed each subsequent school year.

Responsibility of School Nurses and Health Room Assistants

When an EPI Pen is initially brought to a District school, the school nurse or health room assistant shall be responsible to complete the following:

- Obtain the required written request and statement from the parent/guardian and the physician, certified registered nurse practitioner or physician assistant. These will be kept on file in the health room of the building in which the student is enrolled.
- Reviewing pertinent information with the student and/or parent/guardian; specifically the information contained on the statement submitted by the physician, certified registered nurse practitioner or physician assistant.
- Determine the student's ability to self-administer medication, understanding of the policy provisions, and the need for care and supervision.

The school nurse and/or health room assistant will maintain an individual medication log for all students possessing EPI Pens.

Adopted: November 10, 2010

Greensburg Salem School District

EPI Pen – Possession of and Self-Administration by Students

Student's Name _____ Grade _____ Date _____

Attach the required statement from a physician, certified registered nurse practitioner or physician assistant.

Name of Medication _____ Dosage _____ Frequency _____

Parent/Guardian Request/Statement:

As the parent/guardian of the above-named student, I request that the Greensburg Salem School District comply with the prescription or order from my physician, certified nurse practitioner or physician assistant prescribing an EPI Pen for my son/daughter and his/her ability to self-administer. I hereby relieve the District and its employees of any responsibility for the benefits or consequences of the above-listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the District has no responsibility for ensuring the medication is taken. I am aware that any improper use/sharing of the above medication or medication policy violation will result in an immediate confiscation of the medication and loss of privilege to possess the EPI Pen and self-administer the medication.

Signature of Parent/Guardian _____ Date _____

Ability to Self-Administer

The above-named student has demonstrated the ability to self-administer the physician-prescribed EPI Pen as per the requirements of the District's policy (400.49).

Signature of Certified School Nurse _____ Date _____

Student Responsibility

My signature below indicates that I understand the rules and regulations regarding the possession of an EPI Pen and the self-administration of the medication. I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician. I am aware that abuse of this privilege will result in the confiscation of my inhaler.

Signature of Student _____ Date _____