

Dear Parent,

Our records indicate that your child _____ has a potentially severe allergy that may require treatment at school. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the forms, listed below, that will give us the necessary information and authorization to treat your child in an emergency.

1. Dietary Request Form (Parent Letter)
2. Dietary Request Form
3. Specialized Health Care Procedure Form-Physician
4. Specialized Health Care Procedure Form-Parent
5. Food Allergy Action Plan(FAAP) / Emergency Action Plan(EAP)

It is important for your child's safety that we have the proper authorizations and supplies on hand in order to respond in an emergency. We appreciate your help in our effort to provide the best care for your child.

Please have your physician or other licensed health-care provider complete these forms and return them to the school nurse as soon as possible.

Sincerely,

Laurie Kennedy RN, BSN

School Nurse
Attachments

PROCEDURE FOR REQUESTING SPECIAL DIETARY MODIFICATIONS FOR STUDENTS

Dear Parent,

To ensure FWISD is aware of your child's dietary modification needs there are several steps to take for your child's well-being.

1. Dietary request form must be filled out **annually** with a licensed healthcare provider and returned to the nurse at the child's home school.
2. The nurse then submits the form to the dietitian and cafeteria manager.
3. An Individualized care plan meeting is scheduled with nurse, dietitian, teacher, and parent to develop a care plan for your child. Following the care plan meeting, then you will be notified when the special diet can start.

Child Nutrition Services and Health Services have collaborated to devise this procedure and form for ordering special dietary modifications for students. This procedure was developed to ensure that students receive adequate nutrition and schools have the equipment and supplies necessary to meet their needs. Under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. 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 in foods when that need is supported by a statement signed by a licensed medical authority. The physician's statement must identify:

- Child's disability;
- an explanation of why the disability restricts the child's diet;
- the major life activity affected by the disability;
- the food(s) to be omitted from the child's diet, and the food or choice of foods that must be substituted;
- Specific substitutions needed must be specified in a statement signed by a licensed physician.
- The school food authority will decide these situations on a case-by-case basis. Documentation with accompanying information must be provided by a recognized medical authority.
- While school food authorities are encouraged to consult with medical authority, where appropriate; schools are not required to make modifications to meals based on food choices of a family or child regarding a healthful diet.

Please note:

When a food allergen that is not one of the eight major food allergens and is listed on the ingredient list as 2% or less, this food **will be** allowed. (for example: Garlic is listed as 2% or less on the ingredient list, thus garlic is not listed as an allergen for that food); 2.) Fort Worth ISD adheres to evidence based research and agrees with the Food Allergy Research and Education (FARE) practice on soy allergies. The FDA exempts highly refined soybean oil from being labeled as an allergen. Studies show most individuals with a soy allergy can safely eat highly refined soy oil and soy lecithin. Thus, Fort Worth ISD allows soy oil and soy lecithin in the soy allergen diets.



FOOD AND CHILD NUTRITION SERVICES DIETARY REQUEST

STUDENT'S NAME (Last, First) _____ Date of Birth _____ ID _____

Section A.

Disability or severe, life threatening food allergy
Student's diagnosis /disability (REQUIRED):

I. Disability causing a diet modification and/or Severe Life Threatening Food Allergy

Student has allergies that are life threatening/anaphylactic:

- ☐ Yes, continue with this section ☐ No, refer to section B
- ☐ Dairy Allergy: ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese
- ☐ Avoid all dairy products even in baked goods
- ☐ Milk Allergy (Soy milk offered in place of dairy milk)
- ☐ Egg Allergy: ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods
- ☐ No Wheat ☐ No Peanut ☐ No Tree Nut
- ☐ No Fish ☐ No Shellfish ☐ No Soy ☐ No Corn
- ☐ Omit foods "processed in a facility" with above ☒ checked ingredient
- ☐ Other (Please list): _____

II. Texture Modification:

- ☐ N/A
- ☐ Year Round ☐ Temporary: Start: _____ Stop: _____
- Liquids: Solids:
- ☐ Thin (Regular liquids) ☐ Mechanical Soft (chopped)
- ☐ Nectar Thick ☐ Mechanical Soft (ground)
- ☐ Honey Thick ☐ Pureed (Applesauce texture)
- ☐ Pudding Thick

III. Therapeutic Diet Order: (Write specifics in space provided)

- ☐ N/A
- ☐ _____

Section B.

Food Allergy/Intolerance (NOT LIFE THREATENING)

Student without a disability but is requesting special dietary accommodation

* PLEASE ☒ CHECKS either ALLERGY or INTOLERANCE *

☐ ALLERGY ☐ INTOLERANCE

Student's allergy/intolerance to food(s) below:

Does not result in a Life Threatening/Anaphylactic reaction

- I. ☐ Dairy Allergy: ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese
- ☐ Avoid all dairy products even in baked goods Milk ☐ Gluten
- Free/celiac disease ☐ Lactose Intolerance

II. Other food allergies/intolerances:

- ☐ Egg Allergy: ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods
- ☐ No Wheat ☐ No Peanut ☐ No Tree Nut
- ☐ No Fish ☐ No Shellfish ☐ No Soy ☐ No Corn
- ☐ Omit all foods "processed in a facility" with the above ☒ checked ingredients
- ☐ Other (Please list): _____

*Safe Food Substitutions:

Section C. Other Requests:

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/Life Threatening food allergy or food intolerance/allergy as indicated.

Printed Name of Medical Authority _____ DATE _____ ☐ MD/ ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP

Prescribing Physician/Medical Authority: _____
SIGNATURE CONTACT PHONE NUMBER

I understand that it is my responsibility to renew this form before each school year. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Food and Child Nutrition Services office and the school nurse.

PARENT/GUARDIAN SIGNATURE

DATE

ADDRESS/EMAIL

CONTACT NUMBER OF PARENT/GUARDIAN

School Nurse - PLEASE COMPLETE

Student ID # _____ School _____

School RN _____ RN Email _____ Phone # _____

School Café manager _____ Café manager Email _____ Phone # _____

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Revised 6/08/17

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Specialized Health Care Procedure Authorization Form

Physician's Request for School Health Services

The Fort Worth Independent School District Health Services Department Personnel or other designated employees will provide specialized health care procedures when they are required for students to remain in school. The school nurse will coordinate all procedures in the building(s). The Specialized Health Care Procedure Authorization Form must be completed each school year for all specialized health care procedures provided at school. It must include the physician/licensed prescriber's signature and parent/guardian signature.

School Name: _____ **School Year** _____

Name of Student: _____ **DOB** _____

Based on my evaluation as a physician/licensed prescriber, the above named student requires the following health care service(s) in order to be educated at school:

Name of Procedure(s): _____

Effective from: _____ **through** _____

Physical condition for which procedure is to be performed: _____

Times scheduled and indication for procedure: _____

Physician's Directions: _____

Precautions, possible reactions: _____

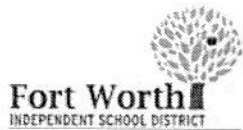
Circumstances in which the physician should be contacted: _____

The following person(s), as designated by the principal, may be trained by the school nurse to perform the above listed procedures: Health Assistant, Teacher, Aide, Secretary/Clerk, and/or Other.

Physician's Name (print) _____ **Signature** _____

Date _____ **Address** _____ **Telephone** _____ **Fax** _____

(page 1 of 2)



Specialized Health Care Procedure Authorization Parent

School Name: _____

Student Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Grade: _____ Gender: _____ Student ID# _____ Homeroom Teacher: _____

*I (we) the undersigned, parents/guardians of _____ request
the following specialized health care service(s) be administered to our child during school hours:*

Name of Procedure(s)

I (we) release those persons designated by our physician to perform the service from all liability.

*I (we) understand that whenever possible the specialized health care service should be provided before or
after school hours.*

*I (we) give permission for the school nurse to consult with the above named student's physician/licensed
prescriber regarding any questions that arise with regard to the listed procedure(s) or medical condition(s)
being treated.*

Signature of Parents/Guardians

Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

*Note: This request must be resubmitted every school year. Medical equipment and supplies provided by the
family for Specialized Health Care Procedures will be sent home for thorough cleaning and/or to be
replaced as needed.*

Student Health History

School Name: _____

Student Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Grade: _____ Gender: _____ Student ID# _____ Homeroom Teacher: _____

FWISD would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Do not hesitate to contact the school nurse.

Parent/Guardian Name(s) _____

Home Phone Number: _____ Work Phone Number: _____ Cell Phone: _____

Last physical exam:	Date:	Routine Check Up	Illness	Injury	Other:
Name of Doctor:					Contact information:

Allergies:	<i>Specify Type:</i>	
Include Food and Medication(s)	<i>Reaction:</i>	

Please indicate with a check (✓) if your child has experienced any of the following conditions:

Conditions:	Past	Present	Please Explain:
Asthma			
Chickenpox			(Date of Disease (Month/Day/Year))
Diabetes			
Heart Condition			
Frequent Headaches			
Urinary/Bowel			
Learning Problems			
Nosebleeds			
Sickle Cell Anemia			
Seizures/Convulsions			(Date of Last Seizure)
Frequent Nausea/Vomiting			
Other condition(s)			

Please Circle Yes or No

Vision Problem:	Glasses	YES	NO	Currently wears	YES	NO	Has worn in past	YES	NO
	Contacts	YES	NO	Currently wears	YES	NO	Has worn in past	YES	NO
Hearing Loss:	Right Ear	YES	NO	Hearing Aid	YES	NO	Frequent Ear Infections	YES	NO
	Left Ear	YES	NO	Ear Tubes	YES	NO	Please Explain:		

Is your child currently taking any medication(s)?	YES	NO	List Medication(s) and Reason:
Has he/she ever taken any other medications in the past on a routine basis?	YES	NO	List Medication(s) and Reason:
Did your child experience any problems at birth?	YES	NO	Please Explain:
Has your child ever been hospitalized for any reason?	YES	NO	Please Explain:
Is there anything more about your child's health that you think is important for us to know?	YES	NO	Please Explain:
Would you like to discuss your child's health with a School Nurse?	YES	NO	Please Explain:

Confidential Protected Health Information: This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law prohibits wrongful use, access or disclosure of protected health information other than as allowed under HIPPA. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal law, as other civil remedies under state law.

Parent Signature: _____ Date: _____

Food Allergy Action Plan

Emergency Care Plan

Place
Student's
Picture
Here

Name: _____ D.O.B.: ____/____/____

Allergy to: _____

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

Extremely reactive to the following foods: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- ☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

Date _____

TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

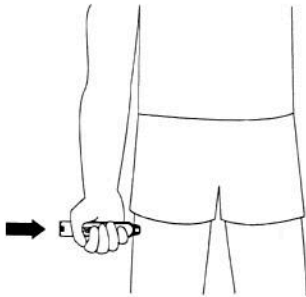
Revised 5/16/13

Como aplicar el EpiPen Auto-inyector y el EpiPen Jr Auto-inyector

1. Primero, saque el EpiPen Auto-inyector del estuche de plástico donde está guardado.
2. Quite la tapa de seguridad azul



3. Sostenga el EpiPen con la punta naranja cerca de la parte externa del muslo (siempre aplicarlo en el muslo)



4. Aplique clavando enérgicamente la punta naranja contra el muslo. Manténgalo contra el muslo durante aproximadamente 10 segundos. Retire el EpiPen Auto-inyector y dé un masaje en la zona durante otros 10 segundos.

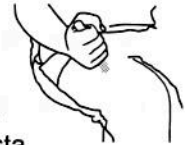


DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Pasos para aplicar Adrenaclick™ 0.3 mg y Adrenaclick™ 0.15 mg



Quitar las dos tapas **GRISES** marcadas como "1" y "2".



Colocar la punta redonda **ROJA** en la parte externa del muslo, presionar con fuerza hasta que penetre la aguja. Mantener 10 segundos, luego retirar.

Un Kit de tratamiento de emergencia ante reacciones alérgicas debe siempre contener al menos 2 dosis de epinefrina, otros medicamentos indicados por el médico del estudiante y una copia de su plan de acción ante reacciones alérgicas alimentarias.

El kit debe acompañar al estudiante si sale de la escuela (ej: viaje/excursión escolar).

Contactos

Llamar 911 (Servicio de Urgencias: () -) Médico: Número de teléfono: () -

Padres: Número de teléfono: () -

Otros contactos en caso de emergencia:

Nombre/Relación: Número de teléfono: () -

Nombre/Relación: Número de teléfono: () -