Holly Area Schools

Severe Allergy Medical Care Plan

This care plan is valid for one (1) school calendar year and must be update by the prescribing physician if any changes are made during the school year

Student's Name: _____ School Year :_____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

ALLERGY: (Check appropriate box and list specific allergen)

☐ Foods: (If nuts, please specify by circling one or both): Peanut Tree Nut Other: _____

☐ Latex

☐ Stinging Insects: _____

☐ Other: _____

History of Asthma: ☐ Yes ☐ No

If your child needs medication at school for asthma, please complete a **separate** Asthma Care Plan.

Contact Information

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _____

Third Contact (If a parent/guardian cannot be reached)

Name: _____ Phone: _____ Relationship: _____

☐ YES ☐ NO I would like to talk with the school nurse regarding my child's allergies.
☐ YES ☐ NO My child is to self-carry their own medication. (A self carry form **must** be signed to self-carry)
☐ YES ☐ NO If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.
☐ YES ☐ NO I have read the attached information regarding section 504 eligibility.
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation.

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician or licensed prescriber.
Without **both** signatures this care plan is not valid. The parent/guardian is responsible for supplying all medication.

I agree to have the information in this two page plan shared with staff as needed. I understand that my child's name may appear on a list with other students having severe allergies to better identify needs. I give permission for Holly Area Schools (HAS) staff to give the medication(s) as ordered on page two of this care plan for allergic reactions and to contact the physician/licensed prescriber for clarification of orders, if needed. I will not hold the HAS Board of Education or its personnel responsible for complications related to the medication.

_____ _____

Parent Signature **Date**

Holly Area Schools do not have medical personnel present to administer medication / treatment. If appropriate, please order medication / treatment to be administered at home.

Holly Area Schools

Student Name: _____ **Date of Birth:** _____ **School Year:** _____

Mild Symptoms

- Give Antihistamine-If prescribed (see below)
- Call parent/guardian & district nurse
- If Symptoms progress: **USE EPINEPHRINE** (see below)

Monitoring

Stay with Student & remain calm
Provide reassurance
Monitor for worsening symptoms

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following (any combination):
Lung: Short of breath, wheezing, repetitive cough
Heart: Pale, faint/weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Tongue or lips swelling, blue around lips, metal taste
Skin: Multiple hives on body, itchy, swelling of an area or face
Gut: Vomiting, cramping like pain, diarrhea
Mental: Anxiety, confusion, sense of impending doom

* If a student is to self-carry epinephrine, help may still be needed to give the medication.

Inject Epinephrine Immediately!
Call 911, then parent/guardian & nurse
Give additional medication* (if ordered)
(Antihistamine or inhaler)
Tell rescue staff that epinephrine was given & time administered. What the suspected allergen was. (**If** having trouble breathing- allow student to sit up). Have student lay down with feet elevated. Roll to side if vomiting. Treat student even if parents cannot be reached.
***2nd dose** may be given if symptoms worsen and help has not arrived.
Start CPR, if necessary.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

☐ 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.

Epinephrine IM (intramuscular) dose: ☐ .15 (junior) ☐ .3 (adult)

☐ **Yes** ☐ **No** - The student has been instructed on how to use the epinephrine injector correctly, knows when to get assistance and not to share their medication. Therefore it is my professional opinion the student should be allowed to self-carry their own epinephrine.

Antihistamine Name: _____ **Dosage:** _____ **Route:** _____

Should antihistamine be administered before Epinephrine, if mild symptoms present? ☐ **Yes** ☐ **No**

Please list parameters for antihistamine use: _____

Other Medication: _____ Dosage: _____ Route: _____
Please list parameters for usage of medication: _____

Other instructions or orders: _____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____

Michigan Department of Education
Office of Health and Nutrition Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant. See back side for instructions.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐Participant has a disability and *requires* a special meal or accommodation (Refer to instructions on reverse side of this form). Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to religious, cultural, economic, or other preferences. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests but are not required to do so. Any meals provided must fully meet the meal pattern. **A school administrator or parent/guardian may sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), nurse, school administrator, or parent/guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation- use extra pages as needed; see instructions on reverse side*)

12. Specific foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed; see reverse side*)

A. Food(s) To Be Omitted: **B. Suggested Substitution(s)**

_____

_____

13. Indicate Texture:

☐Regular ☐Chopped ☐Ground ☐Pureed

14. Adaptive Equipment Needed (if applicable):

15. Signature of Parent/Guardian:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority (if applicable):	20. Printed Name: (include credentials and license/registration number)	21. Telephone	22. Date

This institution is an equal opportunity provider.

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Michigan Department of Education
Office of Health and Nutrition Services

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box to indicate whether participant has a disability and is requesting accommodation or does not have a disability but is requesting special accommodation, and/or fluid milk substitution. Non-disability accommodations are at the discretion of the district and must meet the appropriate meal pattern.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example, *"Allergy to peanuts causes a life-threatening reaction."*
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example, *"All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."*
12. **Specific food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted and what must be offered in their place. Attach additional pages, if needed. For example, *Foods to be Omitted: "peanut butter"* or *"any food containing gluten"* and *Foods to Be Substituted: "peanut-free soy butter or sunflower butter"* or *"gluten-free alternative. If a similar product to what is on menu is not available without gluten, provide a reasonable substitute that does not contain gluten."*
13. **Indicate texture:** Check a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Telephone:** Primary, preferred contact phone number for parent/guardian.
18. **Date:** Date parent/guardian signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation, if it is for a disability or medical condition. If it is not a medical issue, leave this section blank or write "N/A."
20. **Printed Name:** Print name of medical authority, if applicable, including credentials and license number. See #19, above.
21. **Telephone:** Telephone number of medical authority. See #19, above.
22. **Date:** Date medical authority signed form. See #19, above.

Disability Definition: The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). More Information regarding the ADAAA, which expanded the definition of disability, see the Comparison of ADA and ADAAA sheet (http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf).

Special Dietary Needs Management in Schools: For detailed guidance on management of special dietary needs in schools, please see the U.S. Department of Agriculture (USDA) manual, *Accommodating Children with Disabilities in School Meal Programs* in "Guidance and Handbooks" section (https://www.fns.usda.gov/school-meals/guidance-and-resources).