Holly Area Schools

Severe Allergy Medical Care Plan

*This care plan is valid for **one 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): _____

☐ 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.

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 none expired medication.

I certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications at school. I agree to have the information within this medical care plan shared with staff, as needed. I give permission for Holly Area Schools (HAS) staff to give the medication(s) as ordered on this care plan for allergic reactions. I give my permission for staff to contact the physician/licensed prescriber for clarification of these orders, if needed. I will not hold HAS Board of Education or its personnel, or employees responsible for complications related to the medication or treatment/care administered pursuant to this plan.

_____ _____

Parent Signature **Date**

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

 Office Use: Skyward Alert: ___ Email: ___ Food service: _____ Date: _____ Initials: _____

Holly Area Schools

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

Mild Symptoms	**Monitoring**
• Give Antihistamine-If prescribed (see below) • Call parent/guardian & district nurse • If Symptoms progress: **USE EPINEPHRINE** (see below)	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** if **ANY** symptoms are present, if 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)

Authorization for **student to self carry:** ☐ **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:** _____

Special Diet Statement

Why am I being asked to fill out this form?

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.* According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors are not required to accommodate special dietary requests that are not a disability. This includes requests related to religious or moral convictions or personal preference. **If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.**

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. **Updates to this form are required only when a participant's needs change**.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: _____

Participant Information:

Participant's Full Name: _____ Today's Date: _____

Date of Birth:_____

Name of School/Center/Site Attended: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number:_____

Required Information: Dietary Accommodation

1. List the food to be avoided:

   _____

2. Briefly explain how exposure to this food affects the participant:

   _____

3. List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

☐ Other Dietary Modification or Additional Instructions (Describe): _____

*School Nutrition Program –7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4).

Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print):_____Date:_____

Signature:_____Clinic/Hospital:_____

Phone Number:_____Fax Number: _____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to_____**(program name)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional**: 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 authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:_____Date: _____

OR Participant's Signature (Adult Day Care ONLY): _____

USDA Nondiscrimination Statement
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: USDA Program Discrimination Complaint Form, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.