SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Parent Information Packet: Food Allergies Documentation Requested

To the parent of ______________________________________ Date: _________________________

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have a food allergy to: ___________________________________

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special medical diet/food substitution, and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

____

School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

____ This is not a health concern.
____ My child has food allergy(s) as listed and described below:

Food Allergies (Please List): ____

If yes, does this student have an Epi-Pen for a food allergy? ☐ Yes ☐ No

If yes, what allergy(ies) is the Epi-Pen for? ____

Please mark all characteristics/symptoms of your child's allergic reaction:

☐Tightness of throat and/or chest
☐ Wheezing/difficulty breathing
☐ Coughing or Sneezing
☐All over tingling or itching
☐All over rash or hives
☐ Swelling of eyes, lips, tongue, throat or neck
☐ Red Face
☐ Blue or gray discoloration of lips or fingernails
☐ Vomiting, stomach cramping, or diarrhea
☐ Sudden mood change
☐ Anxiety
☐ Irritability
☐ Dizziness
☐ LOC Change
☐ Seizures
☐Other (please describe): ____

Treatment of the food allergy is: ____

___ Observation
___ Oral, with a medication such as Benadryl (please list) ____
___ Injection, such as Epi Pen (please list) ____
___ Other: (please describe): ____

What medication do we need to have at school? ____

PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:

- ☑ **Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet** form signed by a Licensed HealthCare Provider (provide once and update as needed). If this form is NOT submitted to the School Health Office, then the cafeteria can NOT make accommodations for your child.
- ☑ **Food Allergies Medical Management Plan for School** Form signed by an **Arizona Licensed Physician/Health Care Provider** and parent/guardian: If student requires and Epi-Pen
- ☑ **Please see school health staff if your child requires medications to be given at school.**

_________________________________ _________________________________ _________________________________

Name of Parent and/or Guardian Signature Date

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SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

MEDICAL STATEMENT FOR STUDENT WITH FOOD ALLERGY, FOOD RESTRICTION OR SPECIAL NEEDS DIET

(Upon Registration and/or New or changed diagnosis. Update Anytime Food Allergy, Food Restriction, or Special Needs Diet Changes)

PART 1: To be completed by a Parent or Guardian:

Name of Student: ________________________________ Date of Birth ____________ Gender: M F
School: ____Grade: _______ Teacher __________________________
Name of parents/guardians: ____
Home Phone: ______________________Work Phone: ______________________Cell: _________________________

PART 2: To be completed and signed by an Arizona Licensed Physician/Health Care Provider

Patient Diagnosis:____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:____
Food Allergies or Intolerances:____

Are any of these Food Allergies potentially Life Threatening for this student? Yes No
(If Yes, Complete the "Food Allergy Action Plan" and consider prescribing multiple EpiPens (for home, school health office, and to be stored in the classroom or carried by the student as age appropriate) or other necessary medications as needed.
Which Food(s) may be life threatening: ____

Food Substitutions: ____

Indicate which dietary modification the patient needs (if any) and specify what changes need to be made:

____ Texture Modification:
- ____ Pureed
- ____ Ground
- ____ Chopped
- ____ Other ____
- ____ Specify Foods ____

____ Nutrient Modification
- ____ Increase calories Description____
- ____ Supplement Name ____
- ____ Decrease calories Description ____
- ____ Nutrient Restriction Description ____

____ Special Mealtime Equipment: ____

____ Other: ____

Dietician Name and Phone Number (if applicable): ____

Physician's Name ____ **Phone Number:** _______________________

Physician's Signature____ **Date:** _____________________
(Required)

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Food Allergies Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by an **Arizona Licensed Physician/Health Care Provider**

Student's Name:_________________________**D.O.B:**____________**Teacher:**_____________
ALLERGY TO:____
Asthmatic ____Yes ____No *Higher risk for severe reaction

***** STEP 1: TREATMENT *****

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
* If a food allergen has been ingested, but *no symptoms*:	☐Epinephrine ☐Antihistamine
* Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine ☐Antihistamine
* Skin: Hives, itchy rash, swelling of the face or extremities	☐Epinephrine ☐Antihistamine
* Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine ☐Antihistamine
* Throat†: Tightening of throat, hoarseness, hacking cough	☐Epinephrine ☐Antihistamine
* Lung†: Shortness of breath, repetitive coughing, wheezing	☐Epinephrine ☐Antihistamine
* Heart†: Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine ☐Antihistamine
* Other†: ____	☐Epinephrine ☐Antihistamine
* If reaction is progressing (several of the above areas affected), give:	☐Epinephrine ☐Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

*****☐STEP 2: EMERGENCY CALLS ***☐**

1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________________ Phone Number: ____________________________
3. Parent______________________________ Phone Number(s) ____________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name ____ Phone: ___________________

Provider's Signature: ____ Date: ___________________

Parent/Guardian's Name: ______________________________________ Phone Number: ____________________

Parent/Guardian's Signature______________________________________ Date: ____________________

****Additional consent forms required for all medications to be administered during the school day