SAHUARITA UNIFIED SCHOOL DISTRICT #30

SAHUARITA HIGH SCHOOL
SAHUARITA MIDDLE SCHOOL
SAHUARITA PRIMARY SCHOOL
ANZA TRAIL SCHOOL
WALDEN GROVE HIGH SCHOOL
SAHUARITA INTERMEDIATE SCHOOL
SOPORI ELEMENTARY SCHOOL
COPPER VIEW ELEMENTARY SCHOOL
EARLY CHILDHOOD CENTER

SCHOOL HEALTH SERVICES

Parent Food Allergy Information Letter

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	☐ Swelling of eyes, lips, tongue, throat or neck	☐ Anxiety
☐ Wheezing/difficulty breathing	☐ Red Face	☐ Irritability
☐ Coughing or Sneezing	☐ Blue or gray discoloration of lips or fingernails	☐ Dizziness
☐ All over tingling or itching	☐ Vomiting, stomach cramping, or diarrhea	☐ LOC Change
☐ All over rash or hives	☐ Sudden mood 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 a Licensed HealthCare 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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SCHOOL HEALTH SERVICES

Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet
(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 by a Licensed Primary Care Provider/Physician:

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 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 and specify what changes need to be made:

- ☐ Texture Modification:
  - ☐ Pureed
  - ☐ Ground
  - ☐ Chopped
  - ☐ Other _____

  Specify Foods _____
- ☐ Tube Feeding: Formula Name: _____

  Administration Instructions: _____

  Oral Feeding: Yes No If Yes, 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)

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SCHOOL HEALTH SERVICES

Food Allergies Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by licensed Primary Care Provider/Physician

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!

Physician's Name _____ **Phone Number:** _____

Physician's Signature_____ **Date:** _____
(Required)

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____