See the following pages relating to food allergies and health care plans:

Exhibit A: Letter Requesting Additional Documentation for Student Identified as Having a Severe Food Allergy—1 page

Exhibit B: Physician Statement Regarding Meal Substitutions or Modifications—2 pages

Exhibit C: Notice of Student with a Diagnosed Severe Food Allergy —1 page

Exhibit D: Food Allergy Action Plan (FAAP) —1 page

Exhibit E: Anaphylaxis Emergency Action Plan (EAP) – 1 page

Exhibit F: Anaphylaxis Incident Report Form—1 page

Exhibit F: Individualized Health-Care Plan—2 pages

Note: Additional resources and supporting materials, including sample Food Allergy Action Plans (FAAPs) and Emergency Action Plans (EAPs), can be found on the Texas Department of State Health Services' (TDSHS) website at http://www.dshs.state.tx.us/schoolhealth/default.shtm.

A sample Request for Food Allergy Information form can be found at FD(EXHIBIT).

Sample forms regarding Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication, Authorization to Secure Emergency Medical Treatment of a Student, and Request for the Administration of Medication at School can be found at FFAC(EXHIBIT).

EXHIBIT A

SAN FELIPE DEL RIO CISD

LETTER REQUESTING ADDITIONAL DOCUMENTATION FOR STUDENT IDENTIFIED AS HAVING A SEVERE FOOD ALLERGY

Dear Parent or Guardian:

You have disclosed that _____ *(student's name)* has a severe food allergy. The District requires additional information in order to take necessary precautions for the student's safety and to authorize treatment of the student in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Request for the Administration of Medication at School
2. Authorization to Secure Emergency Medical Treatment of a Student
3. Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication
4. Physician's Statement Regarding Meal Substitutions or Modifications
5. Food Allergy Action Plan (FAAP)
6. Anaphylaxis Emergency Action Plan (EAP)

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

Sincerely,

_____

Kristine Gladson, Lead Nurse
District Epinephrine Coordinator

EXHIBIT B

SAN FELIPE DEL RIO CISD
PHYSICIAN'S STATEMENT REGARDING MEAL SUBSTITUTIONS OR MODIFICATIONS

Note: Information regarding accommodating students with special dietary needs can be found on the Texas Department of Agriculture website at http://www.squaremeals.org/Portals/8/files/ARM/Section%2013-Accommodating%20Children%20with%20Special%20Dietary%20Needs.pdf.

The U.S. Department of Agriculture regulations require substitutions or modifications in school meals for students whose disabilities restrict their diets. If a physician or other licensed health-care provider determines that a student's food allergies may result in severe, life-threatening (anaphylactic) reactions, then the student's condition will meet the definition of a disability, and the prescribed substitutions must be made by the District. In order to do so, the school nutrition program must receive a signed statement by the physician or other licensed health-care provider containing the following information:

The student's food allergy that constitutes a disability: _____

_____

An explanation of why the disability restricts the student's diet: _____

_____

The major life activity affected by the disability: _____

_____

The food(s) to be omitted from the student's diet: _____

_____

The food or choice of foods that must be substituted: _____

_____

Physician information:

Name: _____

Address: _____

Phone number: _____

_____ _____
Physician's signature Date

For Office Use Only

Date form was received by the school: _____

Student's name: _____

Date of birth: _____ Grade _____

EXHIBIT C

SAN FELIPE DEL RIO CISD
NOTICE OF STUDENT WITH A DIAGNOSED SEVERE FOOD ALLERGY

[Provide this form to campus staff and substitutes who will be working on the campus.]

This campus has students who have been diagnosed with a severe food allergy. A severe food allergy is an allergy that might cause an anaphylactic reaction. An anaphylactic reaction is a serious allergic reaction that is rapid in onset and may cause death. Classroom teachers must compile an appropriate substitute folder with information regarding whether specific students in the class have been diagnosed with a severe food allergy. Substitutes must carefully review the substitute folder provided by the classroom teacher for information whether specific students in the class have been diagnosed with a severe food allergy. All health information is confidential.

If there is a student with a diagnosed food allergy in the class, please contact the campus nurse for District and campus procedures on food allergy management.

Sincerely,

Principal Date

EXHIBIT D

FOOD ALLERGY ACTION PLAN (FAAP)

SAN FELIPE DEL RIO CISD
FOOD ALLERGY ACTION PLAN

ALLERGY TO:_____

Student's
Name:_____DOB:_____Teacher:_____

Place Child's Picture Here

Asthmatic Yes* ☐ No ☐ *High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems:	Symptoms:
·MOUTH	itching & swelling of the lips, tongue, or mouth
·THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
·SKIN	hives, itchy rash, and /or swelling about the face or extremities
·GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
·LUNG*	shortness of breath, repetitive coughing, and/or wheezing
·HEART*	"thread" pulse, "passing-out"

The severity of the symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION FOR A MINOR REACTION ◆

1. **If only symptom(s) are:**_____, give_____
   medication/dose/route
   _____

Then call:

1. Mother_____, Father_____, or emergency contacts.
2. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. **If ingestion is suspected and/or symptom(s) are:**_____,

give_____**IMMEDIATELY!**
medication/dose/route

Then call:

1. Rescue Squad (ask for advanced life support)
2. Mother_____, Father_____, or emergency contacts.
3. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD

Parent's Signature_____Date_____ Doctor's Signature_____Date_____

EXHIBIT E

SAN FELIPE DEL RIO CISD

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** *(high risk for severe reaction)* ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
**Some symptoms scan be life-threatening. ACT FAST!*

Emergency Action Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
   - ☐ Adrenaclick (0.15 mg)
   - ☐ Adrenaclick (0.3 mg)
   - ☐ Auvi-Q (0.15mg
   - ☐ Auvi-Q (0.3 mg)
   - ☐ EpiPen Jr (0.15 mg
   - ☐ EpiPen (0.3 mg)
   - Epinephrine Injection, USP Auto-injector-authorized generic
     - ☐ (0.15 mg)
     - ☐ (0.3 mg)
   - ☐ Other (0.15 mg)
   - ☐ Other (0.3 mg)

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. **Call 911 or rescue squad (before calling contact)**
3. **Emergency contact #1: home_____work_____cell_____**
   Emergency contact #1: home_____work_____cell_____
   Emergency contact #1: home_____work_____cell_____

Comments: _____

_____

Doctor's Signature/Date/Phone Number

_____

Parents Signature (for individuals under age 18 yrs)/Date

This information is for general puposes and is not intended to replace the advice of a qualified health professional. For more information, visit www.aaaai.org © 2013 American Academy of Allergy, Asthma & Immunology

American Academy of Allergy Asthma & Immunology

7/2013

EXHIBIT F

SAN FELIPE DEL RIO CISD
ANAPHYLAXIS INCIDENT REPORT FORM

Student's name: _____

Date of birth: _____ Grade: _____

Date of incident: _____

If known, the location and source of the allergen exposure:

_____

Emergency action taken (attach additional pages if more space is needed):

_____

_____

_____

Were emergency services contacted?

☐ Yes ☐ No

Was an epinephrine auto-injector used?

☐ Yes ☐ No

If yes, who administered the epinephrine?

☐ Student (self-administration)

☐ Staff (provide name and position title): _____

☐ Other: _____

Are any changes to procedures recommended?

_____

_____

Principal's signature: _____ Date: _____

Received by: _____ Date: _____

EXHIBIT G

SAN FELIPE DEL RIO CISD
INDIVIDUALIZED HEALTH-CARE PLAN

Note: If applicable, a student's individualized health-care plan (IHP) must be coordinated with his or her Section 504 plan. [See FB for information regarding the application of Section 504 of the Rehabilitation Act to students who qualify for individualized health-care plans.]

Student's name: _____

Date of birth: _____ Grade: _____

Primary health concerns/diagnoses: _____

_____

_____

Secondary health concerns/diagnoses: _____

_____

_____

Treating physician(s) information:

Name: _____

Address: _____

Phone number: _____

Name: _____

Address: _____

Phone number: _____

Name: _____

Address: _____

Phone number: _____

Current medications* [see FFAC]:

_____

_____

_____

*Attach the Request for the Administration of Medication at School and/or the Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication found at FFAC(EXHIBIT)–A and C, respectively, as necessary.

Medical equipment:

_____

_____

_____

Diagnosis	Assessment	Goal	Implementation / Intervention**	Anticipated outcome	Evaluation

**Attach an emergency health plan related to student's diagnosis, if necessary.

Effective date: _____

Signature of parent or guardian: _____ Date: _____

Nurse's signature: _____ Date: _____