OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Oakland Unified School District
Health Services Department

OUSD Internal Use Only:
Orders expiration Date_____ Medication Expiration Date_____

School Year_____
Severe Allergy Action Plan

Student's Last Name _____ First Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ Room No. _____

TO BE COMPLETED BY A LICENSED PHYSICIAN

Allergy to:_____ **Asthma**: ☐ Yes (higher risk for severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

☐ **If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten**

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble /swallowing, obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: hives itchy rashes, swelling (e.g. eyes, lips)
GUT: Vomiting, diarrhea, cramping pain

⇒

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medication:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

⇒

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3 .If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

MEDICATIONS/DOSES

Epinephrine (brand and dose):_____ **Exp. Date** _____
Antihistamine (brand and dose): _____
Other (e.g., inhaler-bronchodilator is asthmatic): _____

MONITORING

Stay with student; alert healthcare professional and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first symptoms persist or recur. For a severe reaction, consider keeping student on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Physician's Signature _____ **Print Name (Physician)** _____ **Telephone** _____ **Date** _____

☐ **Permission to carry and self-medicate** **Location of Epi-pen:** _____

Parent Consent for Authorization and Management of Anaphylaxis in School Setting

I (we) undersigned the parent(s)/guardian(s) of the above student, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child in accordance with state law and regulations. I (we) will:

1. Provide the necessary supplies and equipment;
2. Notify the school nurse if there is a change in my child's health status or attending authorized healthcare provider; and
3. Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

Parent(s)/Guardian(s) Printed Name:_____ **Phone Number:** _____
Parent(s)/ Guardian Signature:_____ **Date:**_____
Registered Nurse Signature:_____ **Date:** _____

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of site where meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of parent or guardian.

8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name:** Print name of state licensed healthcare professional.

15. **Phone Number:** Phone number of state licensed healthcare professional.

16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.