

School Year \_\_\_\_\_  
**Severe Allergy Action Plan**

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Room No. \_\_\_\_\_

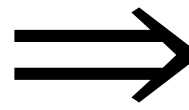
**TO BE COMPLETED BY A LICENSED PHYSICIAN**

**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

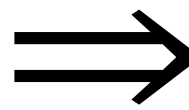
**Any SEVERE SYMPTOMS after suspected or known ingestion:**  
One or more of the following:  
LUNG: Short of breath, wheeze, repetitive cough  
HEART: Pale, blue, faint, weak pulse, dizzy, confused  
THROAT: Tight, hoarse, trouble /swallowing, obstructive swelling (tongue and/or lips)  
SKIN: Many hives 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:   |                  |                                |          |
| <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed |                  |                                |          |
| 11. Foods to be Omitted and Appropriate Substitutions:  |                  |                                |          |
| <b>Foods To Be Omitted</b>  |                  | <b>Suggested Substitutions</b> |          |
|   |                  |                                |          |
|   |                  |                                |          |
|   |                  |                                |          |
|   |                  |                                |          |
|   |                  |                                |          |
| 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.**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

## 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.