Little Chute Area School District
Health Services
FOOD ALLERGY

Samantha Busko, MSN, RN, School Nurse 920-788-7600
Elementary Fax: 920-788-7847 AND IM/MS/HS Fax: 920-788-7841

If your child will be taking hot lunch, it is imperative that you complete the Department of Public Instructions Food Allergy Plan for Hot Lunch. This form will go to our food vendor, TAHER. TAHER is a peanut-free lunch program.

STUDENT INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:	**BUS STUDENT**: *YES* *NO*	

LIST ALL FOODS YOUR CHILD IS ALLERGIC TO:

ALLERGY TYPE *(Circle all that apply)*: *INGESTION* *TOUCH* *AEROSOL*

ASTHMA HISTORY: *YES* *NO* ***Note: A history of asthma increases the risk of anaphylaxis.***

HISTORY OF ANAPHYLAXIS/ALLERGIC REACTION: *YES* *NO*

If yes, describe signs and symptoms during reaction: _____

Has epinephrine ever been administered? *YES* *NO* *If **yes**, when?*

SEVERE ALLERGY & ANAPHYLAXIS TREATMENT

REACTIONS TO WATCH

SEVERE ALLERGY & ANAPHYLAXIS:
If a child has ANY of these severe symptoms after eating food or having a sting, give Epinephrine.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bothers breathing
- Vomiting or diarrhea (if severe)
- Many hives or redness over the body
- A feeling of “doom”, confusion, altered consciousness, or agitation

MILD ALLERGIC REACTIONS:
If a child has had any mild symptoms, monitor the child. Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

STEPS TO TAKE TO REACTIONS

SEVERE ALLERGY & ANAPHYLAXIS (*OR SPECIAL SITUATION IS MARKED*) STEPS:

1. Inject epinephrine right away! Note the time it was given
2. Call 9-1-1.
   - Ask for an ambulance with epinephrine
   - Tell rescue squad when epinephrine was given
3. Stay with the child and:
   - Call parents
   - Give second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes
   - Keep child lying on back. If child vomits or has trouble breathing, move child to lie on side
4. Give other medication, if prescribed. Do not use other medicine in place of epinephrine
   - Antihistamine
   - Inhaler/ bronchodilator

MILD ALLERGIC REACTIONS STEPS:
Stay with the child and:

1. Watch child closely
2. Give antihistamine (if prescribed)
3. Call parents
4. If more than 1 symptom of severe allergy/anaphylaxis develops, give Epinephrine. (See “Severe Allergy & Anaphylaxis”)

SPECIAL SITUATION:

	Check the left box if the child has an **extremely severe allergy** to an insect or these food(s): _____. *Even if the child has **MILD** symptoms after a sting or eating the above foods, give Epinephrine.*

MEDICATION & AUTHORIZATION

Epinephrine (Inject Intramuscularly): (circle one) EpiPen® EpiPen® Jr. Auvi-Q™ 0.3 mg Auvi-Q™ 0.15 mg

Antihistamine (Give): Medication/Dose/Route: _____

Other (Give): Medication/Dose/Route:

CHILD MAY SELF-CARRY: *YES* *NO* *If no, **location** of Epinephrine:*

PARENT/GUARDIAN MEDICATION CONSENT

I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

EMERGENCY CONTACT:	**RELATIONSHIP TO STUDENT:**
(H) PHONE:	**(C) PHONE:**

PARENT/GUARDIAN SIGNATURE:	**DATE:**
PHYSICIANS NAME:	**PHONE:**
PHYSICIANS SIGNATURE:	**DATE:**

ELEMENTARY PARENTS COMPLETE

QUESTION	YES	NO	NOTES
Would you like a food allergy notice letter sent home to your child's classmates?			
If classmates bring their own snacks to class, are there any precautions needed?			
If there is a special occasion treat (ex. birthday) would you like to be notified?			
Would you like to have an alternative snack stored in the classroom or health office? **Teachers try to provide advance notice of special occasions, but please consider keeping alternative snacks in class for when they are unable.*			

What type of follow-up would you like:

_____ Have a special meeting with the classroom teacher and school nurse.
_____ Call or email the classroom teacher on my own.
_____ I understand the classroom teacher will have access to this plan. No additional follow-up is needed.

PARENT/GUARDIAN SIGNATURE:	**DATE:**

Principal's Initials: _____ **Date:** _____