Pierce City Schools

PARENT ALLERGY LETTER

Year_____

___

Dear Parents or Guardian of: _____

Grade: _____

Date: _____

You are receiving this letter because you indicated on the health history form that your child has an allergy.

In order for us to provide the best care for your child, we need your help with the following:

Please check **ONE** of the following:

_____ My child does NOT have a life-threatening allergy and receives NO treatment or medication.

_____ My child still has allergy symptoms but they are NOT considered life-threatening and does NOT receive treatment or medication.

_____ My child still has allergy symptoms but they are NOT considered life-threatening and receives treatment and medication at

_____Home _____School

_____ My child has life-threatening allergy symptoms and receives treatment and medication at

_____Home _____School

If you marked one of the last two choices, we ask that you complete the attached forms and return them to the school nurse as soon as possible, as they are required every school year.

- **Parent Information form** - This gives us important health information related to your child's allergy.
- **Epinephrine and Antihistamine Medication Authorization forms**- This gives the health team and school permission to give allergy medication to your child. Please use the correct form for Antihistamines and Epinephrine.
- **Epinephrine Procedural Information Consent form**—This form gives authorization for the student to carry epinephrine and self-administer. **A physician's authorization and signature is required** (can be noted on the Action Plan/Orders)**.**
- **Allergy and Anaphylaxis Plan/ Physician Orders**—This form explains what the doctor prescribes if your student is exposed to an allergen. Please make sure you sign the bottom of the form where indicated.
  Allergy Action Plan is required from your Physician for life-threatening allergies.
- **Special Meals and/or Accommodations form**—This form allows for special meals and/or accommodations for students who have a disability or medical condition with certain foods/diet. **A physician's authorization and signature is required.**

Should you have any questions or concerns, please feel free to call at

(417) 476-2515 ext. 2100 (Elementary) or ext. 3100 (Middle & High School).

Thank you,

Sarah Elbert, RN
Kristi Barchak, RN
Pierce City R-VI
School Nurses

Pierce City Schools

ANAPHYLAXIS/ALLERGIC REACTION INFORMATION FROM PARENT

Year_____

Student Name_____ DOB_____ Grade_____ Bus #_____

Parent/Guardian_____Phone_____Work #_____

Parent/Guardian_____Phone_____Work #_____

Emergency Contact _____Relationship_____Phone_____

Physician/Clinic _____ Office Phone_____

Does your child see another doctor/clinic for anaphylaxis/allergic reaction? If yes, please fill out Physician information below.

Physician/Clinic _____Office Phone_____

List all medications: Home_____

School_____

What date did the student have their first reaction? _____

How many anaphylactic/allergic reactions has the student had since? _____

When was the student's last anaphylactic/allergic reaction? _____

Has the student ever been hospitalized due to the reaction? _____ Yes _____ No

Does the student have an Epinephrine auto-injector? _____ Yes _____ No **Does the student have asthma?** _____ Yes _____ No

What triggers an anaphylaxis/allergic reaction in the student? (Check all that apply)

- ☐ Bee/Wasp sting
- ☐ Other Insect sting _____
- ☐ Peanuts
- ☐ Tree Nuts
- ☐ Other Nuts _____
- ☐ Plants, flowers, cut grass, pollen
- ☐ Wheat
- ☐ Soy
- ☐ Milk
- ☐ Eggs
- ☐ Fish
- ☐ Shellfish
- ☐ Other Foods_____
- ☐ Other Foods_____
- ☐ Other Foods_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Describe the symptoms the student experiences before or during an anaphylaxis/allergic reaction. (Check all that apply)

- ☐ Hives
- ☐ Difficulty Breathing
- ☐ Paleness
- ☐ Complaints of
  - ☐ Tingling
  - ☐ Itchiness
  - ☐ Metallic taste
- ☐ Vomiting
- ☐ Cramps/Stomach Pain
- ☐ Diarrhea
- ☐ Swelling/itching of the mouth or throat area
- ☐ Loss of consciousness
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Authorization for Release of Medical Information:

I give permission for the school nurse to communicate with my student's doctor concerning their anaphylaxis/allergic reaction and its treatment.

_____ _____ _____

Parent/Guardian Signature | Print Name | Date

Pierce City Schools

Year: _____

Parent/Guardian Authorization for Antihistamine at School

(complete one form for each medication)

Student Name: _____DOB: _____ Grade _____

<u>Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.</u>

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician and date)
- Medication label has the student's first and last name
- The first dose of this medication for the current condition/illness **<u>may not be given at school.</u>**

Please complete the following:

Med Name and Strength (only 1 med per page)	Dosage	Time(s) to be given at school	How it's taken (mouth, eye, skin, ect)	Reason/Medical condition for med administration

Medication Start Date: _____ Medication Stop Date: _____

Note: the first dose of any medication may NOT be given at school

Has the student received this medication before? Yes _____ No _____

If Yes, Date and Time of last dose given _____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the medication to be given by trained personnel as delegated by the Principal.

Please Note: Elementary school students may not carry medication home (except inhalers) and should not transport controlled substances to school, including ADD/ADHD medication; all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the mediation from the School Health Office when it is no longer needed or when the school year ends.

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Reviewed by RN: _____ Date: _____

Pierce City Schools

Parent/Guardian Authorization for Administration of Epinephrine Auto Injector at School

Year: _____

Student Name: _____DOB: _____ Grade _____

Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician and date)
- Medication label has the student's first and last name
- **Epinephrine Auto Injector must not be expired. Exp. Date_____**
- **All sharps are to be disposed of in an approved container** (container located in the Nurse's office).

Please complete the following:

Medication Name and Strength	Dosage	Time(s) to be given at school	Additional Comments

Medication Start Date: _____ Medication Stop Date: _____

Has the student received this medication before? Yes _____ No _____ If Yes, Date of last dose_____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for trained school personnel to assist student with Epinephrine Auto Injector.

Please Note: Elementary school students may not carry medication home (except inhalers) and should not transport controlled substances to school, including ADD/ADHD medication; all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the mediation from the School Health Office when it is no longer needed or when the school year ends.

IF YOU WANT THE STUDENT TO CARRY HIS/HER EPINEPHRINE AUTO INJECTOR the following is required:

- Written request from parent/guardian to allow the student to carry the prescribed Epinephrine Auto Injector and use without supervision (see next page).
- Permission from the school nurse or principal after assessing the student's knowledge and ability to carry and use the auto injector without supervision.
- **WRITTEN AUTHORIZATION FROM THE PHYSICIAN** (can be noted in the Emergency Action Plan from the doctor).

_____ _____ _____

Parent/Guardian Signature | Date | Relationship to Student

Reviewed by RN: _____ Date: _____

Pierce City Schools

Year: _____

Epinephrine Procedural Information with Parental/Guardian and Student Consent to Carry and Self-Administer

Student's Name_____ DOB_____ Grade_____

Information about Epinephrine Procedures

- Please notify the teacher, sponsor or coach about your child's allergy when your child will be staying for any school-sponsored after school activities.
- The health office is closed after dismissal and the school nurse is not in the building. It is suggested that the middle and high school students who are involved in these after school activities carry their own auto-injector for quick access to epinephrine.

_____ _____

Parent/Guardian Signature Date

Parent/Student Agreement for Permission to Self-Administer and/or Carry Epinephrine

PARENT:

- I give my consent for my child to self-administer and/or carry self-carry his/her auto-injector of epinephrine.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of epinephrine.
- This permission to self-administer and/or possess epinephrine may be revoked by the principal if it is determined that your child is not safely and effectively carrying and/or self-administering the medication.
- **A new Physician Order/Care Plan for Severe Allergy (along with physician authorization to carry med) and Parent/Student Agreement for Permission to Carry Epinephrine must be submitted each school year.**

_____ _____

Parent/Guardian Signature Date

STUDENT:

- If I am to self-administer, I have demonstrated the correct use of an auto-injector of epinephrine to the school nurse.
- I agree to never share my epinephrine with another person or use it in an unsafe manner.
- I agree that if I inject epinephrine I will immediately report to the school nurse or another appropriate adult if the school nurse if not available so that EMS can be called as indicated.

_____ _____

Student's Signature Date

Pierce City Schools

Pierce City R-VI Public Schools
Allergy Action Plan / Physician's Orders

Year _____

Student's Information

Name _____ DOB _____ Grade _____

Parent/Guardian _____ Cell _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

☐ The student has demonstrated the skills to carry and self-administer their Epipen. _____

PHYSICIAN AUTHORIZATION SIGNATURE DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

SPONSOR NAME	SITE NAME, IF DIFFERENT	SITE TELEPHONE NUMBER

NAME OF PARTICIPANT	DATE OF BIRTH

NAME OF PARENT OR GUARDIAN	TELEPHONE NUMBER

☐ Participant has a disability or medical condition and requires a meal substitution or accommodation. CACFP institutions, schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.** Food preferences are not an appropriate use of this form. Food preferences may be met with substitutions within the program required meal pattern.

☐ CACFP participant does not have a disability, but is requesting a special accommodation for a fluid milk substitute that meets the nutrient standards for non-dairy beverages offered as milk substitutes. **A parent or guardian may sign this form.** Food preferences are not an appropriate use of this form. CACFP institutions, schools, and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

Note: If a milk substitute is requested that does not meet the nutrient standards for non-dairy beverages, this form must be completed and signed by a licensed physician, physician assistant, or nurse practitioner.

Disability or medical condition requiring a special meal or accommodation. (Describe the medical condition that requires a special meal or accommodation, for example: juvenile diabetes, peanut allergy, etc.):

If participant has a disability or medical condition, provide a brief description of participant's major life activity affected by the disability:

Diet prescription and/or accommodation: (Describe in detail to ensure proper implementation - use extra pages as needed, for example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods.")

Foods to be omitted and substitutions. List specific foods to be omitted and required substitutions; if needed attach a sheet with additional information.

Foods to be omitted	Substituted Foods

Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Adaptive equipment, describe specific equipment required to assist the participant with dining. Examples may include sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.

SIGNATURE OF PREPARER	PRINTED NAME	DATE

SIGNATURE OF MEDICAL AUTHORITY	PRINTED NAME	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant. It is recommended to review the form on an annual basis.

The medical statement should include a description of the participant's physical or mental impairment that is sufficient to allow the program operator to understand how it restricts the participant's diet. It should also include an explanation of what must be done to accommodate the disability. If the medical statement is unclear, or lacks sufficient detail, program operators must obtain appropriate clarification so that a proper and safe meal can be provided.

Definitions.

Disability: a physical or mental impairment which substantially limits one or more "major life activities," a record of such impairment, or regarded as having such impairment.

Major life activities are broadly defined and 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 life activities" also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008.
For more information on documentation required, refer to the CACFP program manuals at: www.health.mo.gov/cacfp.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28- 17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail**: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or
2. **fax**: (833) 256-1665 or (202) 690-7442; or
3. **email**: program.intake@usda.gov

This institution is an equal opportunity provider.