LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

***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. Food Allergy & Anaphylaxis Emergency Care Plan*;
2. LTISD Food Allergy/Intolerance Notification*;
3. Self-Carry/Administration of Medication Authorization*;
4. Request for Medication Administration; and
5. Consent for Disclosure of Confidential Information.

Please complete these forms and return them to your school nurse as soon as possible. Any additional information or documentation that will help assist the campus in recognizing the signs and symptoms of an anaphylactic reaction that your student might experience is also greatly appreciated.

Sincerely,

*LTISD School Health Services*

** These forms must be completed and signed by your physician or other licensed health-care provider*.

# FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

**PLACE PICTURE HERE**

**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: ☐ 0.15 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

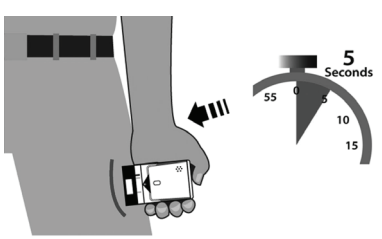
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

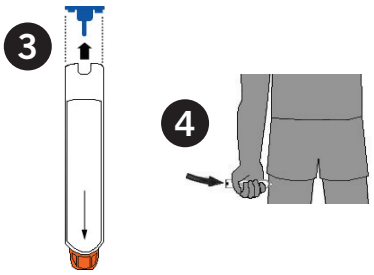
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



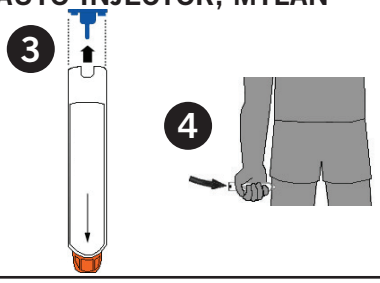

## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



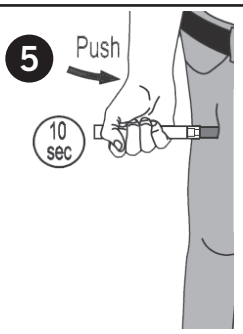

## HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.




## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.




## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

# Lake Travis Independent School District

***Food Allergy/Intolerance Notification***

**This section to be completed by parent or guardian**

**Student Name:**_____ **DOB:**_____ **Student ID:**_____

**Campus:**_____ **Grade:**_____ **Asthma:** ☐ Yes (higher risk for severe reaction) ☐ No

**Parent Name (printed):** _____ **Parent Email:** _____

**All questions must be answered for ANY diet modifications or substitutions to be made in school meals. This section must be filled out ONLY by physician's office -NOT FILLED OUT BY A PARENT/GUARDIAN. *MUST BE SIGNED BY MD, DO, NP or APRN***

**1. Is this a life threatening food allergy/disorder:** ☐ Yes ☐ No

**2. Check all foods that must be omitted:**

☐ Milk/ Dairy ☐ Peanuts ☐ Tree Nuts ☐ Eggs ☐ Wheat ☐Soy ☐ Fish ☐ Shellfish
☐ gluten (wheat, barley, rye, oats) ☐ Other:_____

**3. Can the student consume foods where the allergen is an ingredient?** ☐ Yes ☐ No
(ex: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
Explain if needed:_____

**4. Route(s) by which allergen causes severe reaction:** ☐ Ingestion ☐ Contact ☐ Inhalation

**5. Diagnosis and/or Disability-**please list student's diagnosis and/or disability and how it restricts diet:

_____

**6. Major life activity affected by food allergy or disability** (check all that apply):

☐ Breathing ☐ Eating ☐ Caring for oneself ☐ Performing manual tasks ☐ Walking
☐ Hearing ☐ Speaking ☐ Seeing ☐ Learning ☐Other:_____

**7. Food Substitutions** (please **check all** approved substitutions according to student's allergy):

| **Allergen** | **Substitution** | **Substitution** | **Substitution** |
|---|---|---|---|
| **Milk/Dairy →** | ☐ soy milk | | |
| **Wheat/Gluten →** | ☐ corn tortillas/taco shells | ☐ Gluten-free bread | ☐ Gluten-free pizza/ chicken nuggets |
| **Other allergen→**_____ | | | |

**By submitting this form you are giving consent for LTISD to consult with MD, DO, NP, or APRN: If you do NOT want LTISD FANS to contact the medical office, initial here _____**

*I have read the above orders and agree with this plan of care for my child.*

_____ _____ _____
**Parent Signature** **Phone #** **Date**

_____ _____ _____
**Physician Signature** **Phone #** **Date**

*Notice: Information regarding Lake Travis ISD FANS Food Allergy Process & Information can be found at the link below*
LTISD Food Allergy Process & Information (https://www.ltisdschools.org/foodallergy) *Parents may omit food allergens or severity by way of written consent; any additions or increases in severity of allergy must be amended by MD, DO, PA, or APRN with a new form.* ***This page will go through campus nurse then scanned and emailed to FANS@ltisdschools.org***

**Updated: 04/12/18**

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

# Self-Carry/Administration of Medication Authorization

A responsible, trained student is permitted to carry and/or self-administer medication on his/her person for immediate use in a life-threatening situation with a written order from a physician/prescribing health care provider, parent/guardian request, and school nurse and principal approvals.

Student: _____ Grade: _____ Date of Birth: _____

Condition for which medication is administered: _____

Name of medication: _____ Dose: _____

Method of administration for medication: _____

Timing /Indication for administration of medication: _____

Side effects to be noted/reported: _____

Other recommendations:_____

Dates of administration: From _____ to _____ (not to exceed one school year)

**IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.**

Physician: _____ Telephone(s): _____

Physician's Signature: _____ Date: _____

## Parent/Guardian Authorization

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, the medication name, date of the original prescription, strength and dosage of the medication, and directions for use. No more than a 30 day supply of the medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or the end of the medical order.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

## Principal/School Nurse Approvals

We accept the parent request and physician statement above. We will permit/assist the student to be responsible with this self-carry medication, but reserve the right to withdraw the privilege if student shows signs of irresponsibility, or if there is a reported safety risk. In the event that a safety risk has been determined, the administration will contact parent/guardian as soon as possible.

School Nurse's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

# Request for Medication Administration

Student: _____ Grade: _____ DOB _____ ID #_____

Campus: _____ Teacher (elementary students) _____

Medication: _____ Dosage: _____

To be given: □ Entire School Year - or -

□ The following dates: _____
(individual dates)

Administer: □ Routinely each day at school at the following times: _____

□ As needed

For Daily Medications: □ Yes, please administer daily medication on field trips

□ No, please do not administer daily medication on field trips

Reason for medication: □ ADD/ADHD

□ Pain

□ Other: _____

Physician's Name (and phone number if known) _____

Other meds taken at home: _____

By signing below, I acknowledge that I understand that:

- District personnel will administer medication to my child in accordance with Texas Education Agency and District policies.
- It is the parent/guardian's responsibility to maintain the medication supply.
- Unclaimed medication will be destroyed at the end of the school year.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date_____

For Office Use Only

| | | | |
|---|---|---|---|
| Medication Received by | | Date | |
| Quantity | | Expires | |

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

# Release/Consent to Request Medical Information

**Student Name _____**

**Date of Birth _____ Grade _____ Campus _____**

Please authorize the person named below to request specified records containing confidential information regarding the above-named student.

From: Lake Travis Independent School District

To: _____
Physician to whom the request is made

_____
Campus

_____
Phone number

_____
Address

_____
Address

_____
City/State/Zip

_____
City/State/Zip

_____
Fax

_____
Fax

**Records to be released**

□ Medical History
□ Physician's Orders
□ On-going Communication

**Purpose of Disclosure**

Develop an appropriate health care plan

To clarify student's medical needs

_____ at: _____
School Nurse Phone Number

□ Yes □ No I have been fully informed and understand the school's request for my consent, as described above. This information will be requested upon receipt of my written consent.

□ Yes □ No I understand that my consent is voluntary and may be revoked at any time.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name