



***Letter Requesting Additional Documentation For Student  
Identified As Having A Severe Food Allergy***

Dear Parent or Guardian:

You have disclosed that \_\_\_\_\_ 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 ("FARE" form)\*;
2. LTISD Food and Nutrition Services Food Allergy/Intolerance Notification\*;
3. Self-Carry/Administration of Medication Authorization\*;
4. Request for Medication Administration; and
5. Release/Consent to Request Medical Information.

Forms noted with an asterisk must be completed and signed by an MD, DO, NP, or APRN. Please return these forms 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,

*Nurse*

*Campus*

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy 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

|   |  |   |   |
|---|--|---|---|
| <br><b>LUNG</b><br>Shortness of breath, wheezing, repetitive cough | <br><b>HEART</b><br>Pale or bluish skin, faintness, weak pulse, dizziness | <br><b>THROAT</b><br>Tight or hoarse throat, trouble breathing or swallowing       | <br><b>MOUTH</b><br>Significant swelling of the tongue or lips |
| <br><b>SKIN</b><br>Many hives over body, widespread redness       | <br><b>GUT</b><br>Repetitive vomiting, severe diarrhea                  | <br><b>OTHER</b><br>Feeling something bad is about to happen, anxiety, confusion | <b>OR A COMBINATION</b><br>of symptoms from different body areas.   |

↓ ↓ ↓

- INJECT EPINEPHRINE IMMEDIATELY.**
- 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

|  |  |  |  |
|--|--|--|--|
| <br><b>NOSE</b><br>Itchy or runny nose, sneezing | <br><b>MOUTH</b><br>Itchy mouth | <br><b>SKIN</b><br>A few hives, mild itch | <br><b>GUT</b><br>Mild nausea or discomfort |
|--|--|--|--|

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

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

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- 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: \_\_\_\_\_

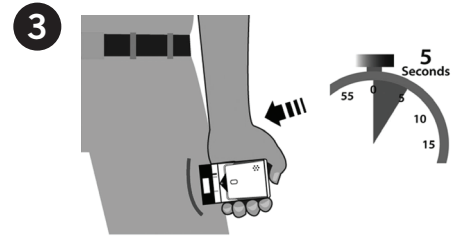
Antihistamine Dose: \_\_\_\_\_

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

\_\_\_\_\_

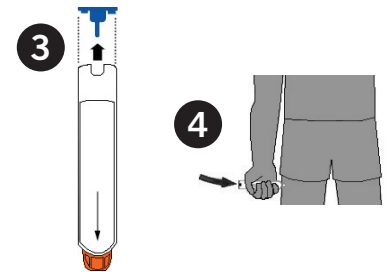
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



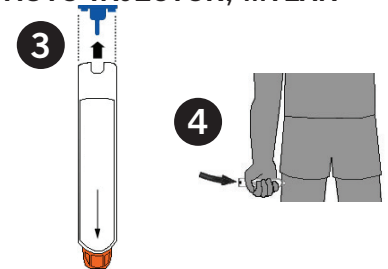
## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.



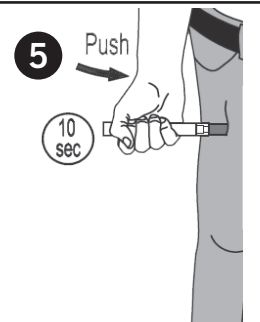
## HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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 ADRENALICK®), 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: \_\_\_\_\_

# Lake Travis ISD Food and Nutrition Services

## Food Allergy/Intolerance Notification

| Part A: to be completed by parent/guardian   |   |
|--|---|
| <b>Student Name:</b><br>_____<br><br><b>Printed Parent/Guardian Name:</b><br>_____ | <b>DOB:</b> _____ <b>Student ID:</b> _____<br><br><b>Campus:</b> _____ <b>Grade:</b> _____<br><br><b>Phone Number:</b> _____<br><br><b>Email Address:</b> _____ |

| Part B: MUST be completed by MD, DO, NP, APRN  |
|--|
| All questions must be answered for any diet modifications or substitutions to be made in school meals. |

**1. Does the child have a disability recognized by the Americans with Disabilities Act?**  
 Yes    No

**2. If the child does NOT have a disability, does the child have a food allergy or intolerance that results in an anaphylactic or adverse reaction when exposed to that specific food?**  
 Yes    No

**3. Please identify the disability, food allergy, or intolerance & describe the major life activities affected.**

**4. Check all foods that affect the child:**

Dairy  
  Peanuts  
  Tree Nuts  
  Eggs  
  Wheat/Gluten  
  Soy  
  Fish  
  Shellfish  
 Seeds (specify) \_\_\_\_\_  
  Other: \_\_\_\_\_

**5. Please describe meal accommodation to be made:** (foods to be omitted or substituted)

|   |                                       |                      |
|---|---------------------------------------|----------------------|
| _____<br><b>Physician's Printed Name or Stamp</b> | _____<br><b>Physician's Signature</b> | _____<br><b>Date</b> |
|---|---------------------------------------|----------------------|

**By submitting this form, you are giving consent for LTISD FANS to consult with the child's MD, DO, NP, or APRN about this condition: 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.*

|                                  |                      |
|----------------------------------|----------------------|
| _____<br><b>Parent Signature</b> | _____<br><b>Date</b> |
|----------------------------------|----------------------|

Notice: Information regarding Lake Travis ISD FANS Food Allergy Process & Information can be found on the Food and Nutrition Services website (<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, NP, or APRN with a new form. **This page will go to campus nurse then scanned and emailed to Food and Nutrition Services.**



## 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: \_\_\_\_\_



## Request for Medication Administration

Student: \_\_\_\_\_ DOB \_\_\_\_\_ Grade: \_\_\_\_\_ Campus: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Take medication:  by mouth  via inhaler  topical (cream)  injection  other \_\_\_\_\_

Condition for which medication is given: \_\_\_\_\_

To be given:  Entire School Year - or -  The following dates: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_

When:  At the following time(s): \_\_\_\_\_ - or -  As needed every \_\_\_\_\_ hours

Special considerations/side effects: \_\_\_\_\_

For Daily Medications:  Yes, please administer daily medication on field trips  
 No, please do not send daily medication on field trips

Other medications taken at home: \_\_\_\_\_

List any food or drug allergies: \_\_\_\_\_

**Must be signed by a physician for any of these reasons:**

- prescription given more than 10 school days (daily medication)
- over-the-counter more than 5 consecutive days
- over-the-counter to be given at higher than labeled dose

**Parent/Guardian:** I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.

|               |        |
|---------------|--------|
| Signature:    | Date:  |
| Printed Name: | Phone: |

**Physician:** I request that the student receive this medication during the school day as instructed above.

|               |        |
|---------------|--------|
| Signature:    | Date:  |
| Printed Name: | Phone: |

**School:** Medication was received by:

|               |             |                    |
|---------------|-------------|--------------------|
| Signature:    | Date:       | Quantity Received: |
| Printed Name: | Phone Ext.: | Expiration Date:   |



## 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

### Purpose of Disclosure

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

- 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