Lake Travis Independent School District
Allergy/Special Dietary Needs/Disability Action Plan

Physician Order Form

Student Name:		DOB:	Student ID:
Campus:	Grade:		Ht: Wt:

Life Threatening Allergy / Special Needs / Disability:

1. **If a food allergy, omit these foods:** (circle all that apply)
A severe food allergy is defined as a dangerous or life threatening reaction to a food-borne allergen introduced by inhalation,ingestion, or skin contact that requires immediate medical attention.

☐ milk/dairy	☐ peanuts	☐ tree nuts	☐ eggs	☐ citrus	☐ strawberry
☐ soy	☐ fish/shellfish	☐ wheat	other:		

2. Medical Professional must indicate route(s) by which the allergen causes severe reaction
☐ **Ingestion** ☐ **Contact** ☐ **Inhalation**

3. Can the student consume foods where the allergen is an ingredient?
(*Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed; fluid milk is omitted but milk as an ingredient is allowed*)
☐ YES ☐ NO Explain_____
_____

4. Major life activity affected by the life threatening allergy or disability
(circle all that apply):

☐ eating	☐ caring for self	☐ manual tasks	☐ walking
☐ seeing	☐ hearing	☐ speaking	☐ breathing
☐ learning	other:		

5. **Foods to Substitute or Modify** as prescribed by MD, DO, NP or APRN

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/Page/64)
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

See Page 2 - Medication order and Signatures

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Medications/Doses

Medication	Brand	Dose/Route
Epinephrine		
Antihistamine		
MDI (if applies)		

Treatment Plan: Physician to check appropriate medication(s)

	Epinephrine	Antihistamine
Exposure to allergen – no symptoms		
Respiratory – wheezing, shortness of breath, coughing		
Cardiovascular – low blood pressure, weak pulse, pallor/blue		
GI – nausea, vomiting, diarrhea, abdominal cramping		
Skin – hives, itching, rash, swelling of face/extremities		
Mouth – swelling lips/tongue, itching, tingling lips		
Throat – tightening, hoarseness, coughing		
Other (explain) -		
Symptoms Worsening		

Parent consent for LTISD to consult with MD, DO, NP, or APRN: (Initial one)

____Yes, I give consent for LTISD nurse and/or FANS RDN to consult with medical team *for any reason*. If I decide to revoke consent at any time, I will notify the school in writing.

____No, I do not give consent for contact *except to clarify orders.*

I have read the above orders and agree with this plan of care for my child. I give permission for LTISD employees to administer these medications to my child. I understand that I am responsible for providing the medication, and that any medication not picked up at the end of the year will be destroyed.

_____ _____ _____

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

Physician recommendations for medication self-administration: (Initial one)

_____The student above has been instructed by me in the proper way to use his/her medication(s). It is my professional opinion that he/she be allowed to carry and self –administer the above medications while on school property or at school related events.

_____The student above in my professional opinion should NOT be allowed to carry and self-administer any of the above medication(s) while on school property or at school related events.

_____ _____ _____

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

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Questions for Parents of Children with Epi-Pens

Name of student: _____

What is your child allergic to:

Level of sensitivity/what causes reaction (circle all that apply):

CONTACT (touch it) ☐ INGESTION (eat it) ☐ PROXIMITY (be near it) ☐

What does their typical reaction look like and how is it treated:

When was the last severe reaction that required an EpiPen:

Do you want the condition to remain confidential (need to know basis, staff only):

YES ☐ NO ☐

If " no" above, do you want the nurse or the teacher to explain to your child's class how your child will look if they have an allergic reaction?

YES ☐ NO ☐

Section 504 of the Federal Rehabilitation Act of 1973, in conjunction with the Amendments Act of 2008 , are designed to prevent discrimination against people with medical disabilities. Federal law requires that we notify all parents of children with a medical disability (in this case, a life-threatening allergy) about the option of creating what is known as a "504 medical plan." In accordance with Texas Education Code and District policy, LTISD employees currently follow an Emergency Care Plan created by your child's physician and communicated to staff by the school nurse. The "504 medical plan" makes the care plan part of a federal document. It is established through a meeting that includes the school counselor, child's teacher, school nurse, and at least one parent. It can be requested or revoked at any time.

Would you like to be contacted in the fall by the school nurse and/or counselor about setting up a meeting to put a 504 medical plan in place?

☐ YES, please contact me in the fall to schedule a 504 conference.

☐ NO, I waive the request to set up a 504 medical plan. LTISD employees are to follow the existing MD plan of care. If I choose to request a 504 at a later time, I will notify the school in writing.

_____ _____ _____

Parent Signature *Printed Name* *Date*