



***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.*

**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

 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
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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

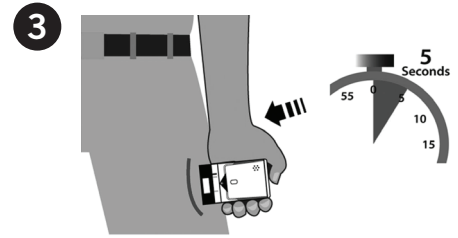
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

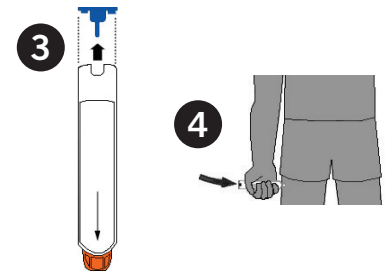
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



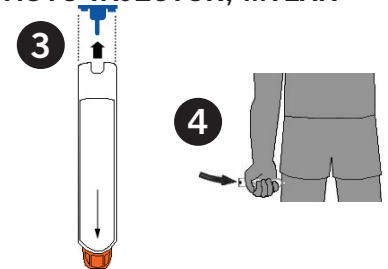
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.



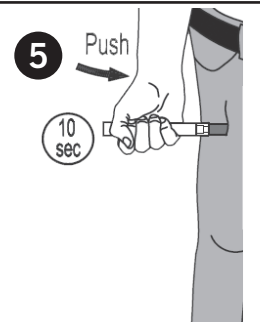
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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 ADRENALCLICK®), 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	
Student Name: _____ Printed Parent/Guardian Name: _____	DOB: _____ Student ID: _____ Campus: _____ Grade: _____ Phone Number: _____ Email Address: _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Please identify the disability, food allergy, or intolerance & describe the major life activities affected. 		
4. Check all foods that affect the child: <input type="checkbox"/> Dairy <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Eggs <input type="checkbox"/> Wheat/Gluten <input type="checkbox"/> Soy <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Seeds (specify) _____ <input type="checkbox"/> Other: _____		
5. Please describe meal accommodation to be made: (foods to be omitted or substituted) 		
_____ Physician's Printed Name or Stamp	_____ Physician's Signature	_____ Date
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 <u>NOT</u> want LTISD FANS to contact the medical office, initial here _____ <i>I have read the above orders and agree with this plan of care for my child.</i>		
_____ Parent Signature		_____ Date

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