Just a reminder!

Dear Parent,

We have noted that you child has a food allergy or food sensitivity that needs our attention.

Please complete the following, and check off when completed:

1. _____ **Food Allergy History** form (parent only).

2. ______ **Food Allergy Action Plan** and **Authorization for Administration of Medication** (doctor and parent).

3. ______ **Physician's Rx for Special Meals at School** (doctor and parent). *This form is needed even if your child does not need medication at school.*

4. ______ Please return these forms and any medication to the enrollment center by ____________________.

******************* IMPORTANT NOTE *******************

The completed forms AND prescribed medication must be received at the enrollment center before your child can attend preschool.

All medication must be in a pharmacy labeled box or in the original box/container (for over-the-counter medication).

Cordially,

Nurse Lisa and Lori

Sacramento City Unified School District
Child Development Department

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Parent

Food Allergy History

(Parent/Guardian to complete and return to Nurse)

Student Name: ______________________________ Date of Birth: ____________________

Parent/Guardian: ____________________________ School: ________________________

Please list any foods your child is allergic to:

Foods	Symptoms (rash, vomiting, difficulty breathing, etc.)	Allergic Reaction is (circle one)				Allergy triggered by (circle all the apply)			
____________	__________________	1	mild	Moderate	severe	1	Eating	Smell	Touch
____________	__________________	2	mild	Moderate	severe	2	Eating	Smell	Touch
____________	__________________	3	mild	Moderate	severe	3	Eating	Smell	Touch
____________	__________________	4	mild	Moderate	severe	4	Eating	Smell	Touch
____________	__________________	5	mild	Moderate	severe	4	Eating	Smell	Touch

In case of accidental exposure:

- Does your child have an Epi-pen? ____
- Does your child have Antihistamine (Benadryl)? ______________________________

Does your child have sensitivities to any non-foods such as paints, animal dander, insect bites? ____

____

Are there any special precautions or concerns you would like to share with the staff? _______

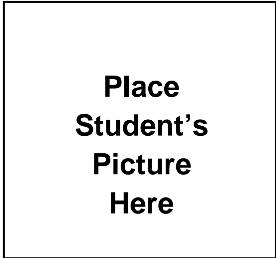
____

____

Parent Signature	Date/Phone	Nurse Signature	Date

Food Allergy Action Plan

Emergency Care Plan



Name: ______________________________ **D.O.B.:** ___/___/___

Allergy to: ______________________________

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

Extremely reactive to the following foods: ______________________________
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

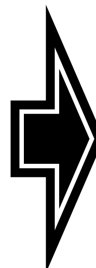
Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ______________________________
Antihistamine (brand and dose): ______________________________
Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

PARENT

______________________ ________ ______________________ ________
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

DOCTOR

____
Nurse Signature / Date

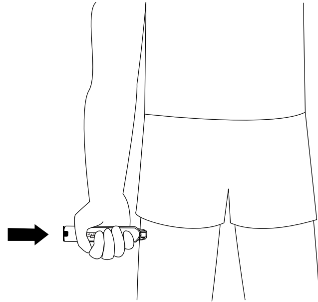
Reviewed with teacher: Initials/Date __________

Routed to: Class file, Emergency Contact Card, Health Cum, Med Bag as needed, Nurse, Parent

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

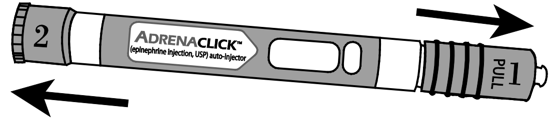
- Hold orange tip near outer thigh (always apply to thigh)

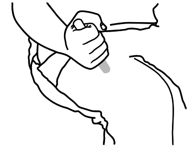


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

DEY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_________) Doctor: _________________ Phone: (___) _____-_________
Parent/Guardian: ____ Phone: (___) _____-_________

Other Emergency Contacts

Name/Relationship: ____ Phone: (___) _____-_________
Name/Relationship: ____ Phone: (___) _____-_________

H.F. 5
Rev. 10-09

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Community, Health and Education Support Services Division
Health Services Office

Doctor

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: this form must be completed each school year or more frequently, if necessary.

I. Basic Legal Provision - California Education Code, Section 49423

Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the name of the medication, method of administration, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

Designated school personnel may administer medication to pupils upon written request of the pupil's parent/guardian and physician **only** when the medication is in the original container.

II. Physician Instructions

Student ____________________ Age __________ Birth date ___________

School ____________________ Grade ________

TO PHYSICIAN: Please note: Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

MEDICATION(S)	DOSAGE	ROUTE OF ADMINSTRATION	APPROXIMATE TIME OF DAY

Diagnosis or indication for medication ____________________

Length of time to be taken ____________________

Precautions or additional instructions ____________________

a. For emergency medication, is the student capable of self-administering the necessary treatment/medication?
☐ Yes ☐ No

b. Will the student need to carry this medication on his/her person? ☐ Yes ☐ No

c. Will the student need to self-administer this medication? ☐ Yes ☐ No

Please note obvious side effects to this particular medication ____________________

____

Signature of Physician ____________________ Address ____________________

Print/Type Physician's Name____________________ Phone ____________ Date ____________

{SR057180.DOC}

III. Parent Request

Parent

Please check one of these boxes.

☑ I/We the undersigned, who am/are the parent(s) of ______________________________ request that medicine be administered to said child by a designated member of the school staff, in accordance with the instructions outlined here and signed by our physician. The medication is to be given at ___*prescribed time*_____ (time) with the following special instructions: __*as ordered by doctor.*____.

☐ As indicated here in our physician's statement, our child, ____________________________, will self-administer his/her own medication when required and we are not requesting school personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her medication at school because he/she suffers from ___________________________ (state nature of illness). Our child will need to take his/her medication _____________________ (number of times per day) with the following special instructions: ____
____
____
____

I/We hereby release, discharge and hold harmless Sacramento City Unified School District and its officers, agents and employees for any and all claims of civil liability arising out of an act or omission that causes our child to suffer an adverse reaction as a result of his/her self-administering medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents, and that we are required to personally bring the medication to school for students kindergarten through 8th grade. We understand that students in grades 9 through 12 may bring their own medication to the school office.

_________________________	_______________	_______________	_______________
Parent/Guardian Signature	Date	Home Phone	Work Phone

____
Address

Emergency contact: ____ Phone: ________________

NUTRITION SERVICES DEPARTMENT
3051 Redding Ave.●Sacramento, CA 95820-2122
(916) 277-6716●FAX (916) 277-6521
Diana Flores, Director

Physician's Rx for Special meals at School

(for the accommodation of severe conditions or food allergies substantially limiting major life activities or major bodily functions)

Rev. 03/19/2018

*USDA Regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose conditions restrict their diets and will be provided substitutions when that need is supported by a statement **signed by a licensed physician** and the condition affects a Major Life-Activity or Major Bodily Function (eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, immune or digestive function). The physician's statement must identify: □ the child's disability, □ an explanation of why the disability restricts the child's diet; □ the major life activity or major bodily function affected by the disability, □ the food or foods to be omitted from the child's diet; and □ and the foods that can be substituted.*

All requests for Special Diets will be reviewed and approved by the Nutrition Services Department. Contact number: 277-6716

PARENT

PARENT

PARENT/GUARDIAN: PLEASE COMPLETE ITEMS # 1-7.
Sign and date the form, take to Doctor and return to School Nurse, Cafeteria or Nutrition Services for processing.

1. Student's Name: ____________ 2. Date of Birth: ________ 3.Grade: ____ 4. School: ________

4. Home Phone # : ________ 5. Daytime Phone # : ________ 6. Other Phone: ________

7.Parent/Guardian Name: ____________ Address: ____________

Signature: ______________________ Date: ________

DOCTOR

PHYSICIAN

PHYSICIAN'S DIETARY STATEMENT FOR CHILDREN WITH DISABILITIES:

8. **Does the student have a disability that restricts his/her diet and limits a major life activity?** (see check boxes below)

Check one box: ☐ **Yes** If "yes", complete the remainder of the form.
☐ **No** If "no", then no meal accommodation is required.

9. **Please check the category into which the child's disability falls**:

☐ Orthopedic impairment requiring texture modification.
☐ Metabolic Conditions or Inborne Errors of Metabolism.
☐ Neuromuscular conditions or diseases affecting the blood.
☐ Food Anaphylaxis (severe food allergy).
☐ Major bodily function: immune or digestive function
☐ Mental / Emotional / Sensory or Learning Disabilities.
☐ Other ____________

MODIFICATION NEEDED:

Texture: ☐ Chopped ☐ Mechanical Soft ☐ Pureed ☐ Tube Feeding

Metabolic: ______ gm CHO ______ gm Pro ______ other

10. Describe the ***disability***; "physical/mental impairment" that restricts a ***major life activity, a major bodily function*** or the ***severe &/or anaphylactic reaction*** resulting from a severe food allergy, and ***why it restricts the child's diet.***

11. **Describe in detail** the diet restriction to ensure proper implementation.

12. Please Indicate foods to Omit:

13. Allergy / Modification Substitutions:

If Eggs - ☐ Omit plain eggs, only
☐ Omit all products containing eggs
If Milk / Dairy - ☐ Omit liquid milk only
☐ Omit all products containing milk
☐ Substitute Lactaid for milk
☐ Substitute water for milk
☐ Other ____________

14. Physican Name: ____________

15. Medical License # : ____________

16. Physician's Signature: ____________

17. Date: ________ 18. Phone # : ________

19. M.D. Office Stamp:

Sacramento City Unified School District is an equal opportunity provider and employer.