The School District of Hernando County, Florida
919 North Broad Street
Brooksville, FL 34601

STUDENT MEDICAL CONDITION NOTIFICATION

FOOD ALLERGIES

Dear Parent,

The school records indicate that your child _____ has been diagnosed with the following medical condition(s):

_____

_____

In order to prepare the staff for a possible emergency concerning your child, the school staff must be made aware of your child's medical condition. Therefore, the school is asking for your permission to confidentially notify the teachers and/or staff members and/or transportation of your child's condition, in order to protect your rights, your child's safety and comply with Florida Statute 1002.22 and 381.0056. The school understands this can be a sensitive situation and assures you that this information will be kept as confidential as possible.

Sincerely,

_____
Principal
_____School

PLEASE SIGN AND RETURN TO YOUR CHILD'S SCHOOL

I hereby give permission for confidential written notification to your staff of my child's medical condition.

Parent Signature: _____ Date: _____

HERNANDO COUNTY SCHOOL DISTRICT

ALLERGY CARE PLAN

School Year _____ - _____

Student Name_____ Date of Birth_____

School Name_____ Grade_____ Teacher_____ Bus_____

Would you like your child to sit at a nut free table at lunch _____yes or _____no

Contact Information:

Parent/Guardian #1_____ Phone#: Home_____ Work_____ Cell_____

Parent/Guardian #2_____ Phone#: Home_____ Work_____ Cell_____

Emergency Contact_____ Relationship_____ Phone#_____

Emergency Contact_____ Relationship_____ Phone#_____

Allergy Specialist_____ Phone#_____

Primary Physician_____ Phone#_____

Hospital Choice: Please circle.

- Brooksville Regional Hospital
- Oak Hill Hospital
- Spring Hill Regional Hospital

Emergency Notification:
Circle the symptoms usually seen for this child (if parent/guardian(s) can't be located, 911 will be called for student in acute distress).

- Shortness of Breath/Difficulty Breathing
- Chest tightness
- Chest Pain
- Wheeze
- Dusky Color
- Lips/Nails Blue in Color
- Rash/Hives
- Straining Neck Muscles
- Itching
- Nasal Flaring (Widening)
- Vomiting
- Diarrhea
- Unable to Speak in Complete Sentences
- Hunched Shoulders

Other_____

Date of Last Allergic Reaction_____

Date of Last Hospitalization_____

Please complete second page.

Student Name_____

ALLERGY MEDICATIONS AT SCHOOL/HOME

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Rescue Treatment:

Name_____ Dosage_____ Frequency_____

DOES STUDENT HAVE CONTRACT TO CARRY EPI PEN? _____YES_____NO

Allergic To: Circle all that apply.

Food (list all/be specific)_____

Insects (be specific)_____

Medications_____

Latex Cats Dogs Mold Sprays Smoke

Environmental Allergies_____

Household Products_____

Seasonal Allergies_____

Other_____

List other emergency procedures for student experiencing allergic signs/symptoms

_____

_____

Parent/Guardian Signature and Date_____

Public Health Nurse Signature and Review Date_____

THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA
HEALTH CARE ACTION PLAN

Student Name _____ Date _____

(Copy to be readily available in classroom and clinic)

EMERGENCY PLAN

IN AN EMERGENCY:

1 . Stay with child

2. Call/ask someone to call clinic assistant who will assess child and summon EMS for this child/or instructor may call EMS.

If You See This	Do This
Based on this child's current condition a **medical emergency** for this child is:	

IMPORTANT EMERGENCY NUMBERS:

Mother's Name: _____ Work (___) _____ Home (___)_____

Cell (___) _____

Father's Name: _____ Work (___) _____ Home (___) _____

Cell (___) _____

Emergency Contact Name: _____ Phone Number: _____

Preferred Hospital: _____

Primary Physician: _____

Specialist(s): _____

DISTRIBUTION:
White : Clinic
Yellow : Teacher
Pink : Parent

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School Name	2. School Telephone Number
3. Student Name	4. Age or Date of Birth
5. Parent or Guardian Name	6. Telephone Number

7. Check One:

☐ The student has a disability or a medical condition and requires a special meal or accommodation (Refer to the definitions on page 2). Schools participating in the National School Lunch Program must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.

☐ The student does not have a disability but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. **Food preferences are not an appropriate use of this form.** Schools participating in the National School Lunch Program are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant or nurse practitioner must sign this form.

8. Disability or medical condition requiring a special meal or accommodation:

9. If the student has a disability, provide a brief description of the student's major life activity affected by the disability:

10. Diet prescription and/or accommodation:
Please describe in detail to ensure proper implementation – use extra pages if needed.

11. Indicate texture modification request (if applicable):
☐ Ground ☐ Soft ☐ Pureed ☐ Liquid

12. Foods to be omitted and substitutions (if applicable):
Please list specific foods to be omitted and suggested substitutions – use extra pages if needed.

Foods to be Omitted	Suggested Substitutions

13. Adaptive Equipment:

14. Parent or Guardian Signature			15. Date
16. Preparer's Signature	17. Printed Name		18. Date
19. Medical Authority's Signature*	20. Printed Name	21. Telephone Number	22. Date

*A physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant or nurse practitioner must sign the form.

INTERNAL USE ONLY:

Date Received by School:	Date Placed in Student Health Record:	Date Copy Given to Food Service:
Recipient's Signature:	Filer's Signature	Recipient's Signature:

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School Name:** Print the name of the school that is providing the form to the parent or guardian.
2. **School Telephone Number:** Print the telephone number of the school.
3. **Student Name:** Print the name of the student to whom the information pertains.
4. **Age or Date of Birth:** Print the age of the student. For infants, please use date of birth.
5. **Parent or Guardian Name:** Print the name of the person requesting the student's medical statement.
6. **Telephone Number:** Print the telephone number of the parent or guardian.
7. **Check One:** Check (✓) a box to indicate whether the student has a disability or does not have a disability.
8. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
9. **If the Student has a Disability, Provide a Brief Description of the Student's Major Life Activity Affected by the Disability:** Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction).
10. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).
11. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the student does not need any modification, skip this question.
12. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods do not need to be omitted, skip this question.
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified milk).
13. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon, plate guard).
14. **Parent or Guardian Signature:** Signature of the person requesting the student's medical statement.
15. **Date:** Print the date the parent or guardian signed the document.
16. **Preparer's Signature:** Signature of the person completing the form.
17. **Printed Name:** Print the name of the person completing the form.
18. **Date:** Print the date the preparer signed the form.
19. **Medical Authority's Signature:** Signature of the medical authority requesting a special meal or accommodation.
20. **Printed Name:** Print the name of the medical authority.
21. **Telephone Number:** Print the telephone number of the medical authority.
22. **Date:** Print the date the medical authority signed the form.

DEFINITIONS*

"A Person with a disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

"Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.

"Has a record of such an impairment" is defined as having a history of or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)