Kimberly Area School District Health Services

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Student's Picture

Student Name:			**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No	***Asthma History:** Yes _____ No _____	
Health Condition: **Food Allergy -**			*History of asthma increases risk of anaphylaxis.	

History of anaphylaxis/allergic reaction? Yes _____ No _____ If **YES**, first line treatment for any subsequent reaction should be epinephrine

If yes, to above, please describe signs and symptoms during reaction:

Has epinephrine ever been administered? Yes _____ No _____ If **YES**, when:

†Potentially life-threatening. The severity of symptoms can quickly change.		**Administer Epinephrine**
Symptoms: Give Checked Medication: To be determined by physician authorizing treatment		
If a food allergen has been ingested, but no symptoms:		Yes No
Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	Yes No
Skin:	Hives, itchy rash, swelling of the face or extremities	Yes No
Gut:	Nausea, abdominal cramps, vomiting, diarrhea	Yes No
Throat†:	Tightening of throat, hoarseness, hacking cough	Yes No
Lung†:	Shortness of breath, repetitive coughing, wheezing	Yes No
Heart†:	Thready pulse, low blood pressure, fainting, pale, blue	Yes No
Other†:	_____	Yes No
If reaction is progressing (several of the above areas affected), give:		Yes No

EMERGENCY PROCEDURE

1. Give appropriate medication as listed.
2. **If Epinephrine is given, call 911**: State that an allergic reaction has been treated.
3. Additional epinephrine may be needed. If symptoms continue, repeat epi-injector after 5-10 minutes.
4. Stay with student and monitor.
5. If self-administered, student must notify school personnel.

****Do not wait for previous symptoms to appear before providing care. Subsequent exposures may look different****

EMERGENCY CONTACT: Name: Phone: Relationship to student:

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TRANSPORT CHILD VIA AMBULANCE TO MEDICAL FACILITY!

FOR COMPLETION BY PHYSICIAN: Physician's Name: Phone:

Epinephrine: give: medication/dose/route _____
Antihistamine: give: medication/dose/route _____
Other: give: medication/dose/route _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Is the child knowledgeable about his or her medication & need to notify school personnel if epinephrine is administered: Yes _____ No _____

Has the child demonstrated the proper technique in administering medication: Yes _____ No _____

Side effects:

( ) I have instructed _____ in the proper way to use his/her injected medications. It is my professional opinion that he/she should be allowed to carry and use this injected medication by him/herself.
( ) It is my professional opinion that _____ should not carry or use his/her injected medication by him/herself.

Physician's Signature: **Date:**

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer Epinephrine: ___Yes ___No

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.
If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself.
I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

I have reviewed the health plan for my child: _____ The plan is correct as written _____ The plan is correct with the changes noted above

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, food service, coaches, bus company and office staff.
Elementary/Intermediate Students ONLY: Yes_____ No_____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice.

Parent Signature: **Date:**

Principal's Initials _____ Rev. 12/2018

FOOD ALLERGIES CARE IN SCHOOL CHECKLIST

School Year: 2019-20	**Grade:**	**Teacher**
Student's Name:		**Date:**
Parent Name:		**Phone:**
Parent name:		**Phone:**
Allergy to (circle those that apply): Ingestion Touch Aerosol		

FOR **PARENT** TO COMPLETE	**YES**	**NO**	**NOTES**
Elementary-Intermediate students ONLY			
Would you like the food allergy letter sent home in your child's classroom?			
If each child brings their own snack to school daily, are there any special precautions needed in the classroom?			
If there is a special occasion treat (birthday or party) would you like to be notified? Would you like to have an alternative snack stored in the classroom or health office for your child?			
Would you like your child to be seated at the "Hot Lunch Only" table? (For nut-peanut allergies only. See cover letter)			
ALL Students			
Will there be Benadryl sent to school for your child?			
Will there be Epi-injector (ie: Epipen) sent to school for your child?			
Do you feel that you would like to: _____ Have a special meeting with the classroom teacher and school nurse _____ Call or email the classroom teacher on my own _____ I understand the classroom teacher will have access to this plan. No additional follow up is needed.			

Anything else you would like your school nurse/school staff to know:

_____

_____

_____

_____

Feel free to call your school nurse with any questions or concerns you may have.

FOR **SCHOOL NURSE** USE ONLY	Yes	No	Notes:
Epipen training for staff			
Epipen training complete			
Email to teacher complete			
Copy to Chartwells, if applicable			
Contact with School Administrator, if applicable			
Other:			

Dear Parent/Guardian,

Kimberly Area School District's food service provider, *Chartwells*, is required by the Department of Public Instruction to have the "**Child with Disabilities and Special Dietary Restrictions**" form on file for any students with special needs (such as food allergies, lactose intolerance or other health conditions affecting diet).

- This form only needs to be completed if you will request a food substitution / special accommodation from Chartwell's. The form is required to be returned with Part A (parent) and Part B (physician) completed. Food substitutions / special accommodations will not be made without this form on file.
- If it is difficult for you to get this form to your physician, please complete Part A and Part B and the school office will fax it to your physician for completion. Be sure to let the office staff know who your physician is.
- If your child will eat the foods currently on the menu with no substitutes, no form needs to be returned.
- This form only needs to be filled out once. New forms will only be needed if you wish to make changes to the original submitted request.

Please note for students with NUT allergies: *While Chartwells does not serve peanuts or peanut butter foods, products served may occasionally be labeled as "manufactured in a facility with" or "may contain traces of peanut". Some foods may contain tree nuts. If you would like to be notified when these products are served in our hot lunch program, please note this under "Indicate any other comments about the child's eating or feeding patterns" on the form for your child. For more information, please contact Chartwells at 423-4159.*

Thank you!

CHILDREN WITH DISABILITIES AND SPECIAL DIETARY RESTRICTIONS

A. *Rehabilitation Act of 1973* and the *Americans with Disabilities Act*

Under Section 504 of the *Rehabilitation Act of 1973* and the *Americans with Disabilities Act* Amendments Act (ADAAA) of 2008, "a person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment.

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. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Please refer to these Acts for more information at http://www.dol.gov/oasam/regs/statutes/sec504.htm and http://www.eeoc.gov/laws/statutes/adaaa.cfm, respectively.

B. Individuals with Disabilities Education Act

A child with a "disability" under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The IDEA can be found in its entirety at http://nichcy.org/wp-content/uploads/docs/IDEA2004regulations.pdf.

The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to make sure that school food service staff is involved early in decisions regarding special meals. If an IEP or 504 plan contain the same information that is required on a medical statement, then it is not necessary to get a separate medical statement from a licensed medical practitioner.

C. Medical Practitioner's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children with disabilities on a case-by-case basis when requests are supported by a written statement from a state licensed medical practitioner.
The practitioner's statement must identify:

- an explanation of how the child's physical or mental impairment restricts the child's diet;
- the food(s) to be avoided; and
- the food or choice of foods that must be substituted.

The second page of this document ("Medical Statement for Special Dietary Needs") may be used to obtain the required information from the licensed medical practitioner.

"Practitioner" is defined by Wisconsin State Statute 118.29(1) (e): "Practitioner" means any physician, dentist, optometrist, physician assistant, advanced practice nurse prescriber, or podiatrist licensed in any state. If the documentation to support a dietary accommodation has not been signed by one of these practitioners, the school is not required to accommodate the request (unless information about the dietary need is included within the IEP or 504 plan, as mentioned above in Section B.).

D. Other Special Dietary Needs

School food service staff may make food substitutions for individual children for whom they do not have a medical statement from a practitioner. It is strongly recommended, though not required, that schools have documentation on file from any medical authority for students with dietary needs for whom they are making menu modifications within the meal pattern. Such determinations are only made on a case-by-case basis and all accommodations must be made according to USDDA's meal pattern requirements.

Dietary Request Form

Please read page 1 before completing this form.

Student's Name	Student's PIN/ID Number	Age*
Name of School*	**Grade Level***	**Classroom***

*Please include information that is accurate as of the time of this form's submission.

1. How does the child's physical or mental impairment restrict his or her diet?

2. Please complete all of the sections below that are applicable to the child.

Allergies and Celiac Disease	What food(s)/type(s) of food should be omitted? Please be specific.	
	List foods to be substituted. (Avoid specific brand names, if possible.)	
Diabetes Mellitus	Please describe any modifications necessary to accommodate the child's needs.	
Texture Modifications	The child requires that all foods be: ☐ Pureed ☐ Diced/finely ground ☐ Chopped/cut into bite-sized pieces	Liquids should be: ☐ Pudding thick ☐ Honey thick ☐ Nectar thick ☐ Thin/normal consistency
Other	What food(s)/type(s) of food should be omitted? Please be specific.	
	List foods to be substituted.	

2. Additional comments:

Parent's Signature	Date
Parent's Name (Please Print)	Phone Number

Signature Below Required (See section C, page 1)

☐ **Physician** ☐ **Nurse Practitioner** ☐ **Dentist**

☐ **Physician Assistant** ☐ **Podiatrist** ☐ **Optometrist**

Please check the appropriate title:

Medical Practitioner's Signature & Date

Medical Practitioner's Name, Title, & Phone Number (Please Print)

Original to: Chartwells Food Director (KHS)
Scan to: IC Documents
Updated 01/17, 11/18