Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Food Allergy and Anaphylaxis Plan

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Allergy to: _____ Weight: _____ lbs.

Is Allergy (check all that apply): Contact ☐ Airborne ☐ Ingestion ☐

Should your child sit at a designated nut free lunch table? Yes ☐ No ☐

Asthma: Yes (higher risk for severe reaction) ☐ No ☐

Complete if your child is EXTREMELY REACTIVE:

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**

For any **SEVERE SYMPTOMS** after suspected or known ingestion:
(one or more of the following)

Lung:	Short of breath, wheezing, repetitive cough
Heart:	Pale, blue, faint, weak pulse, dizzy
Throat:	Tight, hoarse, trouble breathing/swallowing
Mouth:	Significant swelling of the tongue and/or lips
Skin:	Many hives over body, widespread redness
Gut:	Repetitive vomiting, severe diarrhea
Other:	Feeling something bad is about to happen, anxiety, confusion

1. **Inject Epinephrine immediately**
2. **Call 911**
3. Consider giving additional medications:
   a. Antihistamine
   b. Inhaler (if wheezing)
4. Lay person flat with legs elevated.
5. If symptoms don't improve or worsen after 5 minutes, give second dose of epinephrine if available.
6. Alert emergency contacts.

For any **MILD** symptoms from a **SINGLE SYSTEM**:

Nose:	Itchy/runny nose, sneezing
Mouth:	Itchy mouth
Skin:	A few hives, mild itch
Gut:	Mild nausea/discomfort

1. Antihistamine may be given, if ordered by a provider.
2. Stay with person and monitor for changes.
3. If symptoms worsen, give epinephrine if ordered. If given, call 911.
4. Alert emergency contacts.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

☐ My child has a mild reaction and if my child would ingest _____ please call parent. **Medication will not be provided for the school at this time. I understand that if the reaction appears life threatening 911 will be called first.**

Medications/Doses to be given at school:

Epinephrine Brand (Rx label attached): _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM Expiration Date:_____

Antihistamine Brand or Generic:_____

Antihistamine Dose:_____ Expiration Date:_____

Other: (e.g., Inhaler-bronchodilator if wheezing):_____ Exp Date:_____

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date_____

Physician Information

Print Name of Provider_____ **Clinic Name**_____

Phone Number_____ **Fax Number**_____

Address_____

Signature of Provider_____ **Date**_____

Revised 5/2019

CHILDREN WITH DISABILITIES AND SPECIAL DIETARY RESTRICTIONS
Wisconsin Department of Public Instruction

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 https://www.eeoc.gov/statutes/rehabilitation-act-1973 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 https://sites.ed.gov/idea/statuteregulations.

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. Licensed 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 licensed medical 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. Substitutions Within the Meal Pattern
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 USDA's meal pattern requirements.

Medical Statement for Special Dietary Needs

Please read page 1 before completing this form.

Student's Name

Student's PIN/ID Number

Age

Name of School

Grade Level

Classroom

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

2. What food(s)/type(s) of food should be omitted? Please be specific.

3. List foods to be substituted. (Avoid specific brand names, if possible.)

4. Additional comments:

Parent's signature

Parent's name

Date

Phone number

Medical Practitioner's Signature

Medical Practitioner's name

Title

- ◯ Physician
- ◯ Physician assistant
- ◯ Nurse practitioner
- ◯ Podiatrist
- ◯ Dentist
- ◯ Optometrist

Date

Phone number

This institution is an equal opportunity employer.
Updated 10/2020.