Medication Packet for Students With Severe Allergies / Epi-Pen

- Schedule an appointment with your child's health care provider over the summer to update medications and/or obtain new prescriptions.

- Ask the health care provider to complete and sign the Allergy Action Plan.

- Ask the health care provider to complete and sign the Epinephrine Self-Carry Form (if you want your child to carry an Epi-Pen at school).

- Parent: If your child's allergy is food related, complete the Diet Order Form. **An additional FNS Diet Order Form is required to be completed by the physician if the allergies are severe and life threatening.**

- Parent: Complete and sign the Medical Release Form.

- Parent: Read and sign the Medication Authorization Form . A separate form is required for each medication

- Bring all completed forms to the Clinic. Please bring any Epi-Pen with the pharmacy label attached. If Benadryl is prescribed, please bring an unopened package/bottle.

Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

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

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.)_____
b. _____	1.)_____	2.)_____
c. _____	1.)_____	2.)_____

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

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Authorization for Self-carry/Administration of Epinephrine Auto-injector During and After School Sponsored Activities

Florida Statutes, Section 1002.20 House Bill (HB) 279 "Kelsey Ryan Act" specifies that a public school student who has life-threatening allergic reactions may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician written authorization. The school principal shall be provided with a copy of the parent/physician's approval.

Student_____ DOB _____ Grade_____

School _____

Medication: Epinephrine Auto-Injector Dose _____ Administer by: Auto-Injection

Diagnosis _____ Other _____

Health condition signs/symptoms to identify _____

Duration (dates) of Administration: From _____ to _____ (Limit: One year).

I request that my child be allowed to carry/self-administer his/her Epinephrine Auto Injector medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that this medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if she/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____
Parent/Guardian Date Daytime Telephone Number

I agree to terms of this contract. I will keep my Epinephrine auto injector medication in agreed location, will not share this medication with others, and will notify school authorities that I need to administer the medication.

_____ _____
Student Date

I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs/symptoms of anaphylaxis and how to correctly use the auto-injector by me and/or my office staff.

_____
Physician's Name/Stamp

_____ _____
Physician's Signature Date

☐ Extra epinephrine auto-injector in Clinic/Health Room ☐ Original in Clinic/Health Room ☐ Copy to Student

Food & Nutrition Services
Orange County Public Schools

FNS Diet Order for Special Nutritional Needs
Annual Medical Statement for Students

Parent / Guardian (Complete Items 1-8)

(Padre o tutor: Completar la información en los espacios del 1 al 8)(Paran/Gadyen (Konplete Liy 1-8)

1) Student's **Last** Name *(Apellido del estudiante/* Non Elèv La*)*:	2) **First** Name *(Nombre del estudiante/*Prenon Elèv La*)*:	3) Date of Birth *(Fecha de Nacimiento/*Dat Nesans*)* MM / DD / YYYY

4) Choose meals eaten at school ☐ **Breakfast** *(Desayuno/*Dejene*)* ☐ **Lunch** *(Almuerzo/*Manje Midi*)* ☐ **Snack** *(Merienda/*Ti Goute*)* ☐ **Supper** *(Cena/*Manje Aswè*)*

5) Mailing Address *(Dirección Postal/*Adrès*)*: _____

School (*Escuela/*Lekòl): _____

Grade *(Grado Escolar/*Nivo Klas*)*: School Year *(Año Escolar/*Ane Lekòl*)*: 20__ to 20__

6) Parent or Guardian's Signature *(Firma del Padre o Tutor/*Siyati Paran oubyen Gadyen*)*	7) Print Parent or Guardian's name *(Nombre del Padre o Tutor en letra de molde/*Non Paran oubyen Gadyen*)*	8) Parent's phone number Home *(Hogar/*Lakay*)*:_____ Cell *(Móvil/*Telefon Selilè*)*:_____ Email: _____

Cafeteria Manager (Complete Items 9-16)

(Gerente de la Cafetería: Completar espacios del 9 al 16)(Chèf Kwizin Nan: Konplete Liy 9-16)

9) School's name (Include EEC name, is applicable):	10) Check site type: ☐ Prep ☐ Satellite ☐ Finishing School	
11) School Clinic Staff:	12) School Clinic Phone:	13) Is there a Health Care Action Plan in place at the school that includes dietary restrictions? ☐ YES ☐ NO
14) Cafeteria Manager *(CM)*:	15) CM's email:	16) Cafeteria Kitchen's Phone:

COMPLETED BY THE PHYSICIAN ONLY: (Complete Items 17-28)

(Esta sección solamente para ser llenada por el médico. Completar espacios del 17 al 28) (Seksyon Pou Dokte a Sèlman: Konplete Liy 17-28)

17) Does the student have a disability, medical condition or severe food allergy warranting a special diet?

The disability or medical condition must limit a major life activity such as breathing or learning, and the food allergy must result in a reaction that is life-threatening and/or severely impacts the student's ability to function in school. Per USDA law 42 USC 12102(2)(B), major bodily functions include those of the immune, digestive, bowel, bladder, cellular, neurological, brain, respiratory, circulatory, endocrine and reproductive systems.

☐ YES If YES, continue to complete the remainder of this form.

☐ **NO** **If NO, STOP HERE. A SPECIAL DIET IS NOT WARRANTED.**

Operations Division
Orange County Public Schools

Return to School Food Service Manager and Health Assistant

Incomplete request forms will not be processed

Diet Order Form
(Section 1)
School Year 2020 - 2021

OCPS Food & Nutrition Services is committed to the mission and vision of our organization. We aim to serve nutritious meals to all children, including those having medically diagnosed or special dietary needs.
By completing this dietary request form, you are acknowledging the following:

- Your child/student has a dietary need for special meal accommodations including food allergies. Only Section 1 of this form should be completed and signed by the parents. ***(NOT FOOD PREFERENCES)***
- Special Dietary needs and requests, including those related to general health concerns, personal preferences, and moral or religious beliefs are not disabilities and cannot be accommodated.
- When a food modification is necessary because of a medical disability a State Licensed Healthcare Professional must completed and signed Section 2 of this form.

Student Name:_____ **Student ID** _____ **DOB:** _____
School Name: _____ **Teacher:** _____
Mailing Address: _____ **Grade:**_____
Choose meals eaten at school: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper ☐ Does Not Consume School Meals

Does your child/student have food allergies? ☐ Yes ☐ No ☐
Are the food allergies severe or life threatening? ☐ Yes ☐ No

Does your child/student have a medical disability that limits at least one major life activity and require meal modifications outside of the traditional federal meal program? ☐ Yes ☐ No (***If Yes, Section II must be completed by physician***)
Explain: _____

Medical Release statement: I, _____, the official parent/guardian of the child above do hereby consent to the exchange of pertinent dietary information between the physician and school as needed. All Information will be kept confidential.

Physician's Name: _____ Physician's Phone Number: _____

Parent/Guardian Signature: _____

*Please **check the box** of any food allergies or intolerances your child has from this list:*

☐ **Milk and Dairy Products**
- ***For fluid milk only, complete "Fluid Milk substitution" Form***

☐ **Eggs**
☐ **Wheat**
☐ **Soy**
☐ **Peanuts**
☐ **Tree Nuts**
☐ **Fish**
☐ **Shellfish (Not served in school meals)**
☐ **Corn**
☐ **Sesame**

If your child has any other food allergy, such substitution may only be made on a case-by-case basis when supported by a diet modification form signed by a recognized medical authority such as a physician, physician's assistant or nurse practitioner. (Complete Section 2).

****PLEASE COMPLETE SECTION BELOW AND SIGN!***

☐ ***I acknowledge that my child may be identified in the meal service line.***

Print Name of Parent/Guardian: _____
Parent/Guardian Signature: _____
Contact Phone Number: _____
Email: _____
Date of Acknowledgement: _____

Operations Division

Orange County Public Schools

Student's Name: _____ **ID:** _____

School Name: _____

FOR PHYSICIAN USE ONLY (Section 2)

Disability, Medical Condition (i.e. Diabetes, Gastrointestinal Disorders, and Renal Disease), or Severe Food Allergy: Provide a brief description of the **major life activity** (i.e. breathing, learning) affected by the disability or **severe and/or life-threatening reaction** resulting from the food allergy.

_____

_____

Diet Prescription: (For carbohydrate or protein restrictions, include the level allowed for each meal)

_____

_____

Food(s) to be Omitted and Suggested Substitutions:

Food(s) to Omit:	Suggested Substitute(s)

Texture Modification: If needed, select **one** appropriate for the student:

Liquids:

- ☐ Thin
- ☐ Nectar Thin
- ☐ Honey Thick
- ☐ Pudding Thick

Solids:

- ☐ Mechanical Soft (ground)
- ☐ Mechanical Soft (chopped)
- ☐ Pureed (Applesauce Texture)

Physician's Signature:	Physician's Printed Name:	Medical License Number:
Phone Number: Fax Number:	Date:	Name and Phone of Registered Dietitian following student:

Date _____ ***OCPS Registered Dietitian / DTR*** _____

Information regarding the major allergens (Soy, Wheat, Dairy, Eggs, Fish, and Nuts) are available for review by calling 407-858-3110, ext. 3295182 and nutrient information can be found at www.ocpsmenus.com. **Parent/Guardian:** It is **REQUIRED** that this form is returned to the cafeteria manager once completed by the physician for verification.

HEALTHCARE SERVICES LETTER

Dear _____
Physician

_____

_____

Phone #: _____ Fax #: _____

In order to provide health services for: _____, DOB: _____
it is necessary to obtain a medical history, immunization history, and a health plan including a list of current medications administered at home/school.

Please forward all documentation to:

Attn: Danielle Calapa, RN

School: OCPS – Dommerich Elementary

_____

Address: 601 N. Thistle Lane
Maitland, FL 32751

Phone: 407-623-1407 Fax: 407-623-5738

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care plans, immunization history, medical history, and medications) released to my child's school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding current/pending health issues.

_____ _____
Parent/Guardian Date

_____ _____ _____
Home Phone Number Work Phone Cell Number

Teacher:_____ Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Dommerich Elementary School

To assist_____ DOB ___/___/_____

Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask you pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS.** Notes from home will not be accepted as authorization for dispensing medication.

_____ ___/___/___

Signature of parent/guardian Date

(___)_____ (___)_____ (___)_____

Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

Teacher:_____ Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Dommerich Elementary School

To assist _____ DOB ___/___/____

Last First Middle MM/DD/YYYY

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(___)_____ (___)_____ (___)_____

Home phone Work phone Cell phone / Beeper

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