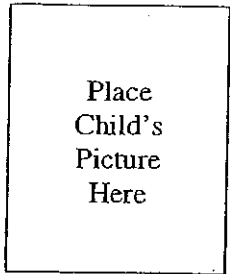


Medication Packet for Students With Severe Allergies / Epi-Pen

- 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: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

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

Give Checked Medication**:

(To be determined by physician authorizing treatment)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

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

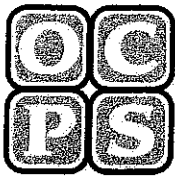
I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs/symptoms of anaphylaxis and how to correctly use the auto-injector by me and/or my office staff.

Physician's Name/Stamp

Physician's Signature

Date

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



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: <input type="checkbox"/> Prep <input type="checkbox"/> Satellite <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 Dokté 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

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

will not be processed

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 complete 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.

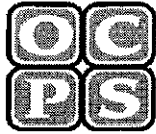
Print Name of Parent/Guardian: _____

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:	Date:	Name and Phone of Registered Dietitian following student:
Fax Number:		

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.** The School Board of Orange County, Florida, does not discriminate in admission or access to, or treatment or employment in its programs and activities, on the basis of race, color, religion, age, sex, national origin, marital status, disability, genetic information, sexual orientation, gender identity or expression, or any other reason prohibited by law. The following individuals at the Ronald Blocker Educational Leadership Center, 445 W. Amelia Street, Orlando, Florida 32801, attend to compliance matters: ADA Coordinator & Equal Employment Opportunity (EEO) Officer: Carianne Reggio; Section 504 Coordinator: Latonia Green; Title IX Coordinator: James Larsen (407.317.3200). In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.



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 _____ Last First Middle _____ DOB ____/____/____
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 _____ Last First Middle DOB ____/____/____
MM/DD/YYYY

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() _____ () _____ () _____
Home phone Work phone Cell phone / Beeper

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