Accommodating Students with Food Allergies Policy

Policy Statement

The Waterbury Board of Education is committed to the safety and health of all students and employees. In accordance with this and pursuant to Connecticut laws Connecticut Public Act No.05-104 (2005), Chapter 170 Sec. 10-220f (1998), Connecticut Public Act No. 05-104 (2005), the purpose of this policy is to:

- Provide a safe and healthy learning environment for students with food allergies;
- Reduce the likelihood of severe or potentially life-threatening allergic reactions;
- Ensure a rapid and effective response in case of severe or potentially life threatening allergic reaction; and
- Protect the rights of food allergic students to participate in all school activities.

Definitions

Food Allergy - Food allergy occurs when the immune system mistakenly attacks a food protein. Ingestion of the offending food may trigger the sudden release of chemicals, including histamine, resulting in symptoms of an allergic reaction.

Anaphylaxis: A sudden, severe allergic reaction occurring in allergic individuals after exposure to an allergen such as food, and insect sting or latex. Anaphylaxis involves various areas of the body simultaneously or causes difficulty breathing and swelling of the throat and tongue. In extreme cases, anaphylaxis can cause death.

In order to properly implement the Board policy pertaining to the management of food allergies, the following administrative regulations are hereby established:

1. Parents with allergic children must provide the school with a physician documented medical history of a food allergy prior to school entry or within a reasonable period of time (Appendix 15b and 15c).

2. Each school shall establish a method of ensuring that relevant information is transmitted to all supervising persons of an identified student. It is incumbent upon the school to notify any person who may be supervising an identified student with food allergies, especially those which may be life-threatening, such as peanut allergies.

3. The primary concern of the school is the prevention and appropriate treatment of potentially severe allergic reaction, anaphylaxis.

Accommodating Students with Food Allergies Policy, continued

4. The school nurse will establish an Emergency Care Plan with the parent/guardian. (Appendix 15a)

5. At risk students who participate in the school system meal plan are identified with a separate alert window in the Food Service POS computer system following the Food Service SOP's.

6. Some food-allergic children bring their lunch from home. However, guidelines established by the USDA Child Nutrition Division in charge of school lunches requires school food service staff to provide substitute meals to severely allergic students if the physician of the student sends in a completed medical statement with written instructions certifying the child's allergy, what foods are to be avoided and safe substitutions. Food Service personnel will maintain an alphabetical log and updated computer list for each action plan and completed medical statement received from the school nurse.

7. Consider establishing a no-food trading policy within the school.

8. Parents are able to review menus on the Waterbury K-12 website in order to select safe foods their child may eat.

9. Consider the following avoidance strategies due to the fact that risk can never be fully eliminated in the school environment:

    a) Parents should be encouraged to instruct their children in strategies for avoiding exposure to substances to which they are allergic, recognize symptoms of allergic reactions, read food labels (age appropriate) and how and when to tell an adult they may be having an allergy-related problem.

    b) Carefully monitor identified children.

    c) Allergic children can consider eating foods that are only prepared at home.

    d) Students should be encouraged not to exchange foods or utensils with other students.

    e) Surfaces, toys and equipment should be washed clean of allergic containing foods.

    f) Food personnel are instructed about necessary measures required to prevent cross contamination during food handling, preparation and serving of food.

    g) Establish a buddy system for identified students.

    h) Provide staff updates at faculty meetings.

    i) Consider a peanut-free table in the cafeteria.

Accommodating Students with Food Allergies Policy, continued

10. Provide training for staff in the recognition of symptoms of an allergic reaction, basic first aid, resuscitative techniques and in the use of epinephrine auto injections.

11. Epinephrine and/or Adrenaline should be kept readily available to students at risk of anaphylaxis and in all cases where it is administered, the student must be sent to the hospital immediately.

Legal Reference:
Connecticut General Statutes:

10-15b Access of parent or guardian to student's records.
10-154a Professional communications between teacher or nurse and student.
10-207 Duties of medical advisors.
Section 504 of the Rehabilitation Act of 1973
Americans with Disabilities Act

Other Reference:

FNS Instruction 783-2, Revision 2, Meal substitution for medical or other special dietary reasons.
"Guidelines for Managing Life Threatening Food Allergies in Connecticut Schools", CT State Department of Education, 2006.
"Accommodating Special Dietary Needs in School Nutrition Programs" CT State Department of Education, November 2011.

Policy adopted by the Waterbury Board of Education on September 6, 2012

INDIVIDUALIZED EMERGENCY CARE PLAN FOR ANAPHYLAXIS

Date initialed: _____ School: _____
Student's Name: _____ Sex: _____ DOB: _____
Parent/Guardian's Name: _____ Telephone # _____
Work # _____ Work # _____

Emergency Contact:
Name _____ Relationship _____ Telephone# _____
Name _____ Relationship _____ Telephone# _____

Physician	Telephone #	Date Last Seen

Student's primary diagnosis, presenting problem, or pertinent background: _____
_____

Emergency Nursing Care Plan for the Management of Anaphylaxis

Specific Allergen: _____
History of Previous Reaction/Dates: _____
_____
_____
Interventions: 1) _____
_____
_____
_____
Note: If Epipen needs to be administered, inject into the upper thigh area only, and hold the Epipen in place for several seconds while the medication is being administered.

2) Call 911 and parent. Transport child to: _____ Hospital
For Bee Allergies only:
Look for stinger, carefully scrape out. Do Not push, pull or squeeze with tweezers or further embed the stinger.
Keep affected body part down below the level of the heart, if possible.
3) Reassure child, lie child flat or in a position of comfort.
4) Monitor airway and cardiac status (pulse). Begin CPR, if indicated.

For Food Allergy only:
Medical Documentation on file (MED-1) ☐Yes ☐No
Copy of this emergency care plan as stated above has been provided to food service personnel.
_____ _____
Date Nurse's Signature

List medication(s) your child is currently taking, how often, and for what reason?

Medications	How Often	Reason

Is there a special way your child behaves when he/she is ill or about to become ill? ☐Yes ☐No
Comments: _____
_____
_____

This care plan has been formulated in collaboration and agreement with the student's parent/guardian. In the event we need additional health information on your child, we will contact your child's health care provider. In the care of food allergy a copy of this care plan will be provided to the food services personnel.

_____
Parent/Guardian's Signature

Telephone Contact: _____ _____ _____

Home Visit: _____ _____ _____

School Office Visit: _____ _____ _____

Date: _____ Nurse's Signature: _____

Review Date: _____ Nurse's Signature: _____

Review Date: _____ Nurse's Signature: _____

This care plan has been reviewed with:

Date/Principal	Date/Teacher	Date/Other School Personnel

Medical Statement for Children *without* Disabilities
Requiring Special Meals in the U.S. Department of Agriculture (USDA) Child Nutrition Programs
(National School Lunch Program, School Breakfast Program, After-School Snack Program, Summer Food Service Program)

This statement must be completed in its entirety and submitted to the school before any meal substitutions can be made for nondisabled children with special dietary needs. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's recognized medical authority.

Part 1 – TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT*

Child's Name: _____ Birth Date____/__/___ ☐Male ☐Female

Parent/Guardian's Name: _____

Work Phone: ___(_____)_____ Home Phone: ___(_____)_____

Address: _____City: _____ State: ____ Zip: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

_____

(Name of Recognized Medical Authority)

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

_____

(Name of School)

and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the school district as necessary. The student's parent is responsible to supply any and all relevant information concerning the student's dietary restrictions in a reasonable period of time. I understand that I may rescind permission to release this information at any time except when the information has already been released. My permission to release this information will expire on

_____

expiration date

*Note: The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.

Parent/Guardian Signature: _____ Date: _____

Part 2 – TO BE COMPLETED BY RECOGNIZED MEDICAL AUTHORITY. *PLEASE PRINT*

The Connecticut State Department of Public Health defines a recognized medical authority as a physician, physician assistant, doctor of osteopathy or advanced practice registered nurse (APRN). This includes nurse practitioners, clinical nurse specialists and certified nurse anesthetists who are licensed as APRNs.

A. Describe the medical or other special dietary need that restricts the child's diet:

B. List foods to be omitted from the diet and foods to be substituted (attach specific diet plan):
*Note: A specific diet plan **must** be provided before the school food service program can make any substitutions for the child.*

C. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."
Cut up or chopped to bite-size pieces:
Finely ground:
Pureed:

D. List any special equipment or utensils needed:

E. Indicate any other comments about the child's eating or feeding patterns:

Name of Recognized Medical Authority: _____ Office Phone Number (___)_____
Signature of Recognized Medical Authority: _____ Date: _____

Office Stamp:

Medical Statement for Children *with* Disabilities

Requiring Special Meals in the U.S. Department of Agriculture (USDA) Child Nutrition Programs

(National School Lunch Program, School Breakfast Program, After-School Snack Program, Summer Food Service Program)

This statement must be completed in its entirety and submitted to the school before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's physician.

Part 1 – TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT*

Child's Name: _____ Birth Date____/__/___ ☐Male ☐Female

Parent/Guardian's Name: _____

Work Phone: ___(_____)_____ Home Phone: ___(_____)_____

Address: _____ City: _____ State: ____ Zip: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

_____

(Name of Recognized Medical Authority)

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

_____

(Name of School)

and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the school district as necessary. The student's parent is responsible to supply any and all relevant information concerning the student's dietary restrictions in a reasonable period of time. I understand that I may rescind permission to release this information at any time except when the information has already been released. My permission to release this information will expire on

_____

expiration date

*Note: The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.

Parent/Guardian Signature: _____ Date: _____

Part 2 – TO BE COMPLETED BY RECOGNIZED MEDICAL AUTHORITY. *PLEASE PRINT*

The Connecticut State Department of Public Health defines a licensed physician, as a doctor of medicine or osteopathy.

A. Describe the patient's disability and the major life activity affected by the disability:

B. Does the disability restrict the individual's diet? ☐Yes ☐No
If yes, the physician must complete C through F sign and stamp the form with the office name an address.

C. List foods to be omitted from the diet and foods to be substituted (attach specific diet plan):
Note: A specific diet plan must be provided before the school food service program can make any meal substitutions for the child.

D. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."
Cut up or chopped to bite-size pieces:
Finely ground:
Pureed:

D. List any special equipment or utensils needed:

E. Indicate any other comments about the child's eating or feeding patterns:

Name of Recognized Medical Authority: _____ Office Phone Number (___)_____
Signature of Recognized Medical Authority: _____ Date: _____

Office Stamp:

Medical Statement for Children *with* Disabilities
Requiring Special Meals in Child Nutrition Programs

Part I *(To be filled out by School)*

Date: _____ Name of Child: _____
School Attended by Child: _____

Part II (*To be filled out by Physician*)

Patient's Name: _____ Age: _____

Diagnosis: _____
_____
_____
_____

Describe the patient's disability and the major life activity affected by the disability:
_____
_____

Does the disability restrict the individual's diet? ☐ Yes ☐ No
If yes, list food(s) to be **omitted** from the diet and food(s) to be **substituted** (Diet Plan):
_____
_____
_____
_____

List foods that require a change in texture:

Cut up or chopped to bite-size pieces: _____
Finely ground: _____
Pureed: _____

Special Equipment Needed:
_____
_____

Date _____ Signature of Physician _____

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, age, or disability. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternate means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

5141.25
Form #1

EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

ALLERGY TO:		
Student's Name:		
DOB:		
Teacher		
Asthmatic	**Yes** ☐*	**No** ☐
	*** Denotes HIGH RISK for severe reaction**	

SIGNS OF AN ALLERGIC REACTION INCLUDE	
Systems:	**Symptoms:**
MOUTH	itching & swelling of the lips, tongue, or mouth
THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	hives, itchy rash, and/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	"thready" pulse, "passing out"
The severity of symptoms can quickly change. ***All above symptoms can potentially progress to a life-threatening situation!**	

Action:

1. If ingestion is suspected, give *(medication/dose/route)* _____ and _____ **immediately!**
2. CALL RESCUE SQUAD: _____
3. CALL: Mother _____ Father _____ or emergency contacts.
4. CALL: Dr._____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____

Parent Signature ***Date*** ***Doctor's Signature*** ***Date***

Emergency Contacts		**Trained Staff Members**	
1.		1.	
Name/Relation	*Phone*	*Name*	*Room*
2.		2.	
Name/Relation	*Phone*	*Name*	*Room*
3.		3.	
Name/Relation	*Phone*	*Name*	*Room*

For children with multiple food allergies, use one form for each food.

SELF-MEDICATION ASSESSMENT

Student: _____ School: _____
D.O.B.: _____ Age: _____ Grade: _____
Physical/behavioral limitations: _____
_____
Name of medication: _____

Self-Medication Criteria:

A. Student is capable of identifying individual medication. Yes No
Comments: _____
_____

B. Student is knowledgeable of purpose of individual medication. Yes No
Comments: _____
_____

C. Student is able to identify/associate specific symptom occurrence and need for medication administration. Yes No
Comments: _____
_____

D. Student is capable/knowledgeable of medication dosage. Yes No
Comments: _____
_____

E. Student is knowledgeable about method of medication administration. Yes No
Comments: _____
_____

F. Student is able to state side effects/adverse reactions to medication. Yes No
Comments: _____
_____

G. Student is knowledgeable of how to access assistance for self if needed in an emergency.
Yes No
Comments: _____
_____

H. An Individual Health Care Plan has been developed for the student which will monitor and evaluate the student's health status. Yes No

Based on assessment:

_____ The student is not a candidate for a self-medication program at this time.
_____ The student is a candidate for a self-medication program with supervision.
_____ The student has successfully completed self-medication training and has demonstrated appropriate self-administration.

Comments: _____
_____

Principal/Teacher notified Yes No

Nurse's Signature _____ Date _____

Medical Statement for Children *without* Disabilities Requiring Special Meals in Child Nutrition Programs

Part I ***(To be filled out by School)***

Date: _____ Name of Child: _____
School Attended by Child: _____

Part II (*To be filled out by Medical Authority*)

Patient's Name: _____ Age: _____

Diagnosis: _____
_____
_____
_____

Describe the medical or other special dietary needs that restrict the child's diet:
_____
_____

List food(s) to be omitted from the diet and food(s) to be substituted (Diet Plan):
_____
_____
_____
_____
_____

List foods that require a change in texture:

Cut up or chopped to bite-size pieces: _____
Finely ground: _____
Pureed: _____

Special Equipment Needed:
_____
_____

Date _____ Signature of Medical Authority _____

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, age, or disability. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternate means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Medical Statement for Children *with* Disabilities Requiring Special Meals in Child Nutrition Programs

Part I ***(To be filled out by School)***

Date: _____ Name of Child: _____
School Attended by Child: _____

Part II (*To be filled out by Physician*)

Patient's Name: _____ Age: _____

Diagnosis: _____
_____
_____
_____

Describe the patient's disability and the major life activity affected by the disability:

_____
_____

Does the disability restrict the individual's diet? ☐ Yes ☐ No
If yes, list food(s) to be **omitted** from the diet and food(s) to be **substituted** (Diet Plan):

_____
_____
_____
_____

List foods that require a change in texture:

Cut up or chopped to bite-size pieces: _____
Finely ground: _____
Pureed: _____

Special Equipment Needed:

_____
_____

Date _____ Signature of Physician _____

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, age, or disability. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternate means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

FOOD ALLERGY TREATMENT PLAN AND PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

PATIENT'S NAME:_____ DATE OF BIRTH:_____

PATIENT'S ADDRESS:_____ TELEPHONE: _____

CAAC PHYSICIAN'S NAME:_____ PATIENT'S PCP: _____

ASTHMA ☐ YES ☐ NO

SPECIFIC FOOD ALLERGY: _____

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:
_____Observe patient for symptoms of anaphylaxis** for 2 hours
_____Administer **adrenaline** before symptoms occur, IM EpiPen Jr. Adult
_____Administer **adrenaline** if symptoms occur, IM EpiPen Jr. Adult
_____Administer **Benadryl____** tsp. or Atarax_____ tsp. Swish & Swallow
_____Administer_____
_____Call 911, transport to ER if symptoms occur for evaluation, treatment and observation for 4 hours

IF REACTION OCCURS,
PLEASE NOTIFY THIS OFFICE! Physician's Signature _____Today's Date_____

1. Is this a controlled drug? ☐ Yes ☐ No Time of administration: _____

2. Medication shall be administered from _____to_____(dates)

3. Relevant side effects, if any, to be observed:_____

4. Other Suggestions: Please allow child to self-administer medication if able to _____

*Signature:*_____ *M.D.* *Date:*_____

****SYMPTOMS OF ANAPHYLAXIS**

Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue, throat
Itching mouth, itchy skin
Hives or swelling
Stomach cramps, vomiting, or diarrhea
Dizziness or faintness

I have received, reviewed, and understand the above information.

_____ _____
Patient/parent/guardian signature Date