CHRISTINA SCHOOL DISTRICT
Educating each student to succeed
www.christinak12.org

Gauger-Cobbs Middle School
50 Gender Road
Newark, DE 19713
School Nurse
(302) 454-2357 Ext: 105

Student Name_____ **Date**_____

Dear Parent/Guardian,

According to the information on your student's health record and/or emergency card, your student is listed as having food allergies and/or allergies to medications, latex, insect bites, or other. For your student's safety, it is **extremely** important that the school nurse, teachers and cafeteria staff know the presence and severity of these allergies. Please complete the following information, sign as indicated and return to the Nurse's office as soon as possible.

My student has allergic reactions to the following:

_____

The reactions include: _____

Has the allergic reaction ever required a visit to the doctor or the emergency room? _____

_____

If so, what treatment was given? _____

Was an EpiPen prescribed? _____

If so, please send an Epi-Pen in the original box with prescription label to the nurse and have your health care provider complete a Food Allergy Action Plan and provide that to our school.

Parent/Guardian Signature_____**Date**_____

Thank you for your prompt response.

Sincerely,

Kathleen Luna, BSN, RN
School Nurse

Dan Shelton, Ed.D., Superintendent

Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME:	DATE OF BIRTH:
SCHOOL:	GRADE:

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- ☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
- ☐ General: panic, sudden fatigue, chills, fear of impending doom
- ☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth
- ☐ Respiratory: shortness of breath, repetitive coughing, wheezing
- ☐ Skin: hives, itchy rash, swelling about face or extremities
- ☐ Throat: feeling tightness in the throat, hoarseness, hacking cough
- ☐ Other: _____

Treatment:

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

Student may carry & self-administer epinephrine
☐ YES ☐ NO

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:	Substitutions:	Foods to omit:	Substitutions:
☐ Eggs		☐ Milk	
☐ Whole	_____	☐ Milk	_____
☐ Ingredient in Recipe	_____	☐ Cheese	_____
☐ Other	_____	☐ Whey	_____
☐ Wheat	_____	☐ Ingredient in Recipe	_____
☐ Gluten	_____	☐ Other	_____
☐ Trace Amount	_____	☐ Nuts	_____
☐ Ingredient in Recipe	_____	☐ Tree Nut	_____
☐ Soy	_____	☐ Peanut	_____
☐ Soy Lecithin	_____	☐ Other	_____
☐ Oil	_____	☐ Fish	_____
☐ Isolated Soy Protein	_____	☐ Shellfish	_____
☐ Ingredient in Recipe	_____	☐ Other Not Included on List	_____
☐ Other	_____		

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____

Asthma: (circle) YES NO _____

Response for reaction to all other allergens: *Give prompt treatment if the student has any of the following symptoms:*

_____

_____

Treatment:

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO APPA Date: _____

Healthcare Provider Name (signature): _____ Phone: _____

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: _____ **Date:** _____ **Phone #:** _____

CHRISTINA SCHOOL DISTRICT

Gauger Middle School

50 Gender Road
Newark, DE 19713
302-454-2357

Parental Request/Permission to Have Medication Administered in School

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container. If a prescription, the container must be properly labeled with correct name, time, dose, date, and prescribing licensed healthcare provider.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- Pick up the medication from school at the end of the school year.

Date ______________________________

Student's Name ____

Medication ____

Dose ______________________________ Time ______________________________

Reason for Medication ____

Allergies to any medications ____

Number of tablets sent ______________

Amount of liquid ______________

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that he/she is required to use nursing judgment regarding all medication administration. I give my permission for medication administration by the school nurse

Parent/Guardian Signature____

— — — — — — — — — — — — — — — — — — —

Nurse's Signature ______________________________

Number of tablets/amount of liquid received ______________________________