NEWHALL SCHOOL DISTRICT
COLLABORATE I INNOVATE I PERSEVERE I EXCEL

25375 Orchard Village Road, Valencia, CA 91355
District Office: 661-291-4000 District Fax: 661-291-4001
www.newhallschooldistrict.net

Dear Parent,

You have indicated that your child has a food allergy**.** Enclosed you will find important forms to help us best care for your child during the upcoming school year:

- ✓ **Allergy Prevention Plan**- This plan is what will be used by teachers and staff to help prevent an allergic reaction from occurring at school. Please review and initial next to your responsibilities, and review with your child their responsibilities (as developmentally appropriate).

- ✓ **Severe Allergy Action Plan-** If your child will need emergency medication at school, please complete and return this form. This plan must be completed and signed by both a health care provider and a parent/guardian, and **must be renewed each new school year**.

- ✓ **Severe Allergy History Form**- Please complete/update this information for the district nurses.

- ✓ **Special Meals Accommodation Form:** If your child will be eating any meals at school from the cafeteria and will need accommodations for their allergy, please have this form filled out by your child's healthcare provider.

We kindly ask that you return the included forms and any corresponding pharmacy-labeled medications (if needed) during school office hours. Thank you for your helping us to care for your child while they are at school. Please contact the district nurses for any questions or health concerns.

Sincerely,

Newhall School District Nurses
Sandi Gault MSN, RN
Danielle Ewing BSN, RN
Colette Sims BSN, RN

(661) 291-4184

Newhall School District DATE: ________

Student Food Allergy Prevention Plan

School Year: ____________________

Student Name:_________________________ DOB:_____Teacher:___________________ Grade: __

ALLERGY TO: ____

SPECIAL NOTES:____

Please review and initial next to your responsibilities, and return this plan to the school health office.

Teacher:

__ Know what your student is allergic to, and help eliminate exposures in and out of the classroom.

__ Reinforce the “no food sharing” or “no food trading” rule.

__ Encourage your students to wash their hands after they eat, and make sure desks/tables in your classroom are wiped after food is eaten or used.

__ Use nonfood items for classroom projects, academic rewards, and classroom celebrations.

__ Make sure any food brought in to your class is store-bought with clearly labeled ingredients, not home-prepared.

__ Review student’s Emergency Allergy Action Plan. Know how to recognize signs and symptoms of anaphylaxis, and know how to respond in an emergency.

__ Look out for and report, bullying or teasing, related to food allergies.

__ Ensure guest-teachers, your NSD classroom aides, curriculum specialists, PE teachers, and other education specialists the student may see during the day, are aware of the allergy.

__ Notify the health assistant and parent at the beginning of the year (or as soon as possible), of all upcoming field trips, so that they can plan accordingly.

Teacher Name: ________________________________

Health Assistant/Office:

__ Provide parent with allergy packet and follow up with needed health forms.

___ Inform the school nurse, teacher, cafeteria, yard supervisors, administrators, and office staff of the allergy.

__Note if parent has requested that the student eat at a peanut-free table.

__ Document allergy in aeries and add to your log of students with allergies.

__ Inform district nurse of any medication you have received for student.

__ Ensure that this care plan has been read and signed by staff.

__ Ensure that emergency medication is clearly labeled and accessible in the event of an emergency.

__ Review emergency response plan, and how to react in the event of an anaphylactic emergency.

__ Prepare for field trips in advance.

Health Assistant Name:

____

Newhall School District DATE: ________

Student Food Allergy Prevention Plan

School Year: ______________________

Yard Supervisor:

____ Be aware of the student's food allergy, and know if the parent has requested the student eat at a peanut-free table.

_____ Reinforce the "no food sharing" or "no food trading" rule.

_____ Encourage students to wash their hands after eating, especially if you see peanut butter on them.

_____ Wipe down tables after each group of students eat.

_____ Review the emergency action plan. Know how to recognize signs and symptoms of anaphylaxis, and know how to respond in an emergency.

_____ Look out for and report any observed bullying or teasing related to food allergies.

_____ Monitor peanut-free tables to ensure that no food items made with peanuts or containing peanuts is brought to, or eaten at the table.

Yard Supervisor Names: ______________________________/_____________________________/______________________

_________________________/___________________________/__________________________/_______________________

Parent:

__ Be involved and communicate with your child's teacher, the school health assistant, and the school nurse.

__ If possible, send in your child's lunch and snacks from home.

__ If your child is eating from the cafeteria, review the food items that are safe for them to eat before each day, using the Santa Clarita Food Service Agency website (http://www.scvschoolnutrition.org/) or phone app.

__ If your child will be eating regularly from the cafeteria, and will need special meal accommodations, return the Special Meals Accommodation Form, signed by your child's doctor (provided in the allergy packet).

__ Consider keeping "safe snacks" in the classroom for unplanned events.

__ For classroom events that involve food, consider providing the classroom teacher with safe snacks for the entire class so that your child can eat what everyone else does.

__ Provide updated allergy forms and medication order forms (if needed) before the start of each new school year.

Parent(s) Name: ____

____

Student:

___ Learn everything that you are allergic to, and practice communicating it with others.

___ Do not share or trade food.

___ Do not eat food that is offered to you, without first checking with an adult who knows your allergens (like a parent or teacher).

___ Wash your hands before and after eating.

___ Report bullying or teasing.

Student's Name:

____

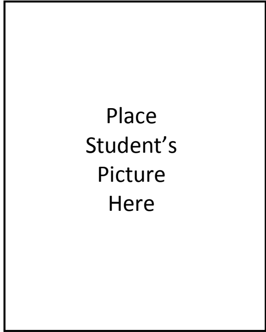
Rev 3/19/18

School Year: ____________________

Teacher: ________________________

Grade: _______

NEWHALL SCHOOL DISTRICT
SEVERE ALLERGY ACTION PLAN
Emergency Care Plan



Name:____ D.O.B: ______/______/______

Allergy to: ____

Reactions previously noted: ____

Current Weight:_____ lbs. **Asthma: ☐Yes (higher risk for a severe reaction) ☐ No**

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- ✓ **Difficulty breathing, wheezing, or repetitive cough**
- ✓ **Swelling of face, neck, or tongue**
- ✓ **Tightness in throat, hoarseness, drooling, or difficulty swallowing.**
- ✓ **Pale, blue, faint, weak pulse, dizzy, confused**
- ✓ **Vomiting, diarrhea, crampy abdominal pain**

1: **INJECT EPINEPHRINE IMMEDIATELY**
2: Call 911
3: Begin monitoring (see box below)
4: May give additional medications (if ordered):
   - Antihistamine
   - Inhaler (bronchodilator) if asthma
5: Give second dose of epinephrine after 5 minutes if severe symptoms persist

MILD SYMPTOMS ONLY:

- ✓ **Red, watery eyes**
- ✓ **Itchy, runny nose, sneezing**
- ✓ **Rash, hives, redness or swelling of localized area**
- ✓ **Itching, tingling mouth, throat, or tongue WITHOUT OTHER SYMPTOMS**

1: **GIVE ANTIHISTAMINE**
2: Stay with student; alert healthcare professionals and parent
3: If symptoms progress (see above), **USE EPINEPHRINE**
4: Begin monitoring (see box below), parent must pick student up.

Medications/Doses:

Epinephrine (brand):_________________________________ ☐ 0.15 mg ☐ 0.3mg

Antihistamine (brand):_______________________________ ☐12.5 mg ☐25mg ☐ 50mg ☐____ mg every☐ 4hrs ☐6hrs

Other (e.g., inhaler-bronchodilator if asthmatic)(brand):______________________________ ____ puffs every☐4hrs ☐6hrs

Possible Side Effects: ____

MONITORING

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. **For a severe reaction**, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See Epinephrine for auto-injection technique.

________________________ ___________ ___________________________________ ________

Parent/Guardian Signature Date Physician Signature Date

Printed/ Stamped Physician Name and Phone Number: ____

Parent/Guardian Contact Information:

1st Contact ______________________________Phone#__________________________Alt phone # ______________________

2nd Contact: _____________________________Phone#__________________________Alt phone # ______________________

I would like my child to sit at a peanut-free table: ☐ YES ☐NO

Rev. 6/2017

NEWHALL SCHOOL DISTRICT

FAMILY SEVERE ALLERGY HEALTH HISTORY FORM

Student Name: ______________________ Date of Birth: ____________

Parent/Guardian: ______________________ Today's Date: ____________

Home Phone: ____________ Work: ____________ Cell: ____________

Healthcare Provider: ______________________ Phone: ____________

Allergist: ______________________ Phone: ____________

1. Does your child have a diagnosis of an allergy from a healthcare provider? No☐ Yes ☐

2. History and Current Status:

a. What is your child allergic to?

	Peanuts		Insect Stings
	Eggs		Fish/Shellfish
	Milk		Chemicals
	Latex		Vapors
	Soy		Tree Nuts(walnuts, pecans etc)

1.

Other: ____________

b. Age of student when allergy first discovered: ____________

c. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain:
____

d. Date of last reaction: ____________

e. Date of last ER visit: ____________

f. Are the food allergy reactions: ☐ Same ☐ Better ☐ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms and your student's allergic reaction? (Be specific; include things the student might say.) ____________
____

b. How does your child communicate his/her symptoms? ____________

c. How quickly do symptoms appear after exposure? _____ secs. _____ mins. _____ hrs. _____days

d. Please circle the symptoms that your child has experienced in the past:

Skin:	Hives	Itching	Rash	Flushing	Swelling (face, arms, hands, legs)
Abdominal:	Nausea	Cramps	Vomiting	Diarrhea	
Throat:	Itching	Tightness	Hoarseness	Cough	
Mouth:	Itching	Swelling (lips, tongue, mouth)			
Lungs:	Shortness of breath		Repetitive Cough		
Heart:	Weak Pulse		Loss of consciousness		

4. Treatment

a. How have past reactions been treated? ____________

b. Was there an emergency room visit? ☐ No Yes, explain: ____________

c. What treatment or medication had your healthcare provider recommended for use in an allergic reaction?
____

d. Have you used the treatment or medication? No Yes

e. Please describe any side effects of the treatment: ____________
____

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes ☐ Usually

b. Does your student:

1. Know what foods to avoid? ☐ No ☐ Yes
2. Ask about food ingredients? ☐ No ☐ Yes
3. Read and understands food labels? ☐ No ☐ Yes
4. Tell an adult immediately after an exposure? ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace, or watchband? ☐ No ☐ Yes
6. Tell peers and adults about the allergy? ☐ No ☐ Yes
7. Firmly refuses a problem food? ☐ No ☐ Yes

c. Does your child know how to use emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family/Home

a. How do you feel that the whole family is coping with your student's food allergy? ☐ Good ☐ Fair ☐ Poor

b. Does your child carry epinephrine on their person in the event of a reaction? ☐ No ☐ Yes ☐ Usually

c. Has your child ever needed to self-administer that epinephrine? ☐ No ☐ Yes

d. Does the parent carry epinephrine in the event of a reaction? ☐ No ☐ Yes ☐ Usually

e. Has the parent ever needed to administer epinephrine? ☐ No ☐ Yes

f. Do you feel that your child needs assistance in coping with his/her allergy? ______________________________

____

Helpful websites: www.foodallergy.org; www.aanma.org; www.medicalert.org

7. General Health

a. How is your child's general health other than having a severe allergy? ______________________________

b. Does your child have other health conditions? ______________________________

c. Hospitalizations? ______________________________

d. Does your child have a history of asthma? ☐ No ☐ Yes

1. If yes, does he/she have an inhaler at school? ☐ No ☐ Yes

e. Please add anything else you would like the school to know about your child's health: ______________

____

____

☐ **I understand information about my child's allergy will be shared with staff and food service as needed.**

Parent/Guardian Signature: ______________________________ **Date:** ______________

Notes: ____

____

Reviewed by R.N.: ______________________________ **Date:** ________

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Dear Parent,

You have indicated that your child has a food allergy, intolerance, or special food need. We would like to help ensure their safety while they are in our care, and one way we do that is by working and communicating closely with the Santa Clarita Valley Food Service Agency (SCVFSA).

SCVSFSA is made up of a team of food and nutrition professionals that are dedicated to students' health, well-being, and their ability to learn. The SCVFSA works hard to ensure that students have access to a variety of affordable and appealing foods that meet their health and nutrition needs.

If your child will be eating any meals at school from the cafeteria and need accommodations as a result of their allergy or illness, we ask that you please take time to have this form filled out by your child's doctor. This form will help to ensure that your child's nutrition needs are met safely.

We also encourage you to spend some time on the SCVFSA website: http://www.scvschoolnutrition.org/ . The website is interactive and can help you choose foods that are safe for your child to eat. In addition, you can download the "Web Menus" App on your smart phone (Add "Santa Clarita Food Service Agency" as your district) for another way to interact with the dining choices for the school day, and to review allergen warnings of food items offered. The website and apps are a great resource for you as a parent to help ensure that your children are eating what is healthy, what they like, and what is safe for them to eat.

Please let us know if you have any questions, and thank you for helping us care for your children during the school day.

District Nurses

Sandi Gault MSN, RN

Danielle Ewing BSN, RN

Colette Sims BSN, RN

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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, sex, disability, age, 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 Agency (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: http://www.ascr.usda.gov/complaint_filing_cust.html, 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 mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of site where meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of parent or guardian.

8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name:** Print name of state licensed healthcare professional.

15. **Phone Number:** Phone number of state licensed healthcare professional.

16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

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.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.