SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Food Allergy History

Student Name: _____ Date of Birth:_____

Parent(s)/Guardian(s): _____ Preschool: _____

Please list any food your child is allergic to:

Foods	Symptoms (rash, vomiting, difficulty breathing, etc.)	Allergic reaction is (circle one)			Allergy triggered by (circle all that apply)		
1 _____	_____	Mild	Moderate	Severe	Eating	Smell	Touch
2 _____	_____	Mild	Moderate	Severe	Eating	Smell	Touch
3 _____	_____	Mild	Moderate	Severe	Eating	Smell	Touch
4 _____	_____	Mild	Moderate	Severe	Eating	Smell	Touch

In case of accidental exposure:

Does your child have an Epi-pen?_____

Does your child have Antihistamine (Benadryl)? _____

Does your child have sensitivities to any non-foods (paint, animal, etc.)? _____

_____

Are there any special precautions or concerns you would like to share with staff? _____

_____

_____

_____ _____

Parent Signature Date/Phone Nurse Signature Date

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

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

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

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)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

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. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

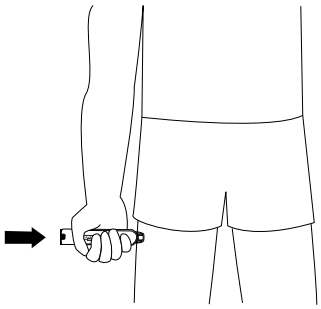
TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**

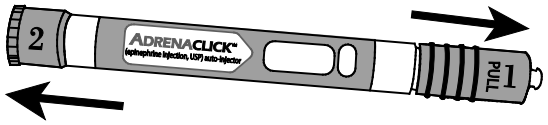


- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

H.F. 5
Rev. 10-09

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Community, Health and Education Support Services Division
Health Services Office

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: this form must be completed each school year or more frequently, if necessary.

I. Basic Legal Provision - California Education Code, Section 49423

Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the name of the medication, method of administration, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

Designated school personnel may administer medication to pupils upon written request of the pupil's parent/guardian and physician **only** when the medication is in the original container.

II. Physician Instructions

Student _____ Age _____ Birth date _____

School _____ Grade _____

TO PHYSICIAN: Please note: Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

MEDICATION(S)	DOSAGE	ROUTE OF ADMINSTRATION	APPROXIMATE TIME OF DAY

Diagnosis or indication for medication _____

Length of time to be taken _____

Precautions or additional instructions _____

a. For emergency medication, is the student capable of self-administering the necessary treatment/medication?
☐ Yes ☐ No

b. Will the student need to carry this medication on his/her person? ☐ Yes ☐ No

c. Will the student need to self-administer this medication? ☐ Yes ☐ No

Please note obvious side effects to this particular medication _____

_____

Signature of Physician _____ Address _____

Print/Type Physician's Name_____ Phone _____ Date _____

III. Parent Request

Please check one of these boxes.

☐ I/We the undersigned, who am/are the parent(s) of _____ request that medicine be administered to said child by a designated member of the school staff, in accordance with the instructions outlined here and signed by our physician. The medication is to be given at _____ (time) with the following special instructions: _____.

☐ As indicated here in our physician's statement, our child, _____, will self-administer his/her own medication when required and we are not requesting school personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her medication at school because he/she suffers from _____ (state nature of illness). Our child will need to take his/her medication _____ (number of times per day) with the following special instructions: _____
_____
_____
_____

I/We hereby release, discharge and hold harmless Sacramento City Unified School District and its officers, agents and employees for any and all claims of civil liability arising out of an act or omission that causes our child to suffer an adverse reaction as a result of his/her self-administering medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents, and that we are required to personally bring the medication to school for students kindergarten through 8th grade. We understand that students in grades 9 through 12 may bring their own medication to the school office.

_____ _____ _____ _____

Parent/Guardian Signature | Date | Home Phone | Work Phone

_____

Address

Emergency contact: _____ Phone: _____

NUTRITION SERVICES DEPARTMENT
3051 Redding Ave.●Sacramento, CA 95820-2122
(916) 277-6716●FAX (916) 277-6521
Brenda Padilla, Director

Sacramento City Unified School District

Physician's Rx for Special meals at School

(for the accommodation of severe conditions or food allergies substantially limiting major life activities or major bodily functions)

Rev. 7/07/2014

USDA Regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose conditions restrict their diets and will be provided substitutions when that need is supported by a statement ***signed by a licensed physician*** *and the condition affects a Major Life-Activity or Major Bodily Function (eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, immune or digestive function). The physician's statement must identify: □ the child's disability, □ an explanation of why the disability restricts the child's diet; □ the major life activity or major bodily function affected by the disability, □ the food or foods to be omitted from the child's diet; and □ and the foods that can be substituted.*

All requests for Special Diets will be reviewed and approved by the Nutrition Services Department. Contact number: 277-6716

PARENT

PARENT/GUARDIAN: PLEASE COMPLETE ITEMS # 1-7.
Sign and date the form, take to Doctor and return to School Nurse, Cafeteria or Nutrition Services for processing.

1. Student's Name: _____ 2. Date of Birth: _____ 3.Grade: ____ 4. School: _____

4. Home Phone # : _____ 5. Daytime Phone # : _____ 6. Other Phone: _____

7.Parent/Guardian Name: _____ Address: : _____

Signature: _____ Date: _____

PHYSICIAN

PHYSICIAN'S DIETARY STATEMENT FOR CHILDREN WITH DISABILITIES:

8. **Does the student have a disability that restricts his/her diet and limits a major life activity?** (see check boxes below)

Check one box: ☐ **Yes** If "yes", complete the remainder of the form.
☐ **No** **If "no", STOP** and complete Request for Food Substitutions at School

9. **Please check the category into which the child's disability falls**:

☐ Orthopedic impairment requiring texture modification.
☐ Metabolic Conditions or Inborne Errors of Metabolism.
☐ Neuromuscular conditions or diseases affecting the blood.
☐ Food Anaphylaxis (severe food allergy).
☐ Major bodily function: immune or digestive function
☐ Mental / Emotional / Sensory or Learning Disabilities.
☐ Other _____

MODIFICATION NEEDED:

Texture
☐ Chopped ☐ Mechanical Soft ☐ Pureed ☐ Tube Feeding

Metabolic
____ gm CHO ____ gm Pro ____ other

10. Describe the ***disability*** ; "physical/mental impairment" that restricts a ***major life activity, a major bodily function*** or the ***severe &/or anaphylactic reaction*** resulting from a severe food allergy, and ***why it restricts the child's diet.***

11. **Describe in detail** the diet restriction to ensure proper implementation.

12. Please Indicate foods to Omit:

13. Allergy / Modification Substitutions:

If Eggs -
☐ Omit plain eggs, only
☐ Omit all products containing eggs

If Milk / Dairy -
☐ Omit liquid milk only
☐ Omit all products containing milk
☐ Substitute juice for milk
☐ Substitute water for milk
☐ Other _____

14. Physican Name: _____

15. Medical License # : _____

16. Physician's Signature: _____

17. Date: _____ 18. Phone # : _____

19. M.D. Office Stamp:

NUTRITION SERVICES DEPARTMENT
3051 Redding Ave.●Sacramento, CA 95820-2122
(916) 277-6716●FAX (916) 277-6521
Brenda Padilla, Director

Sacramento City Unified School District

Request for Food Substitutions at School

(for the accommodation of food intolerances or special dietary needs)

Rev. 7/07/2014

All requests for Special Diets will be reviewed and approved by Nutrition Services. Contact number: 277-6716

*Children without disabilities, but with special dietary needs requiring food substitutions or modifications, **may** request that the school food service meet their special nutrition needs.*

✔ *The school food authority will decide these situations on a case by case basis. Documentation with accompanying information must be provided by a recognized medical authority. (MD, PA or NP)*

✔ ***This form is not intended to accomodate personal preferences.***

PARENT/GUARDIAN: PLEASE COMPLETE ITEMS # 1-7. Print name, sign, date, take to Medical Authority, and return to the school Nurse or Cafeteria for processing. Although every effort is made to adhere to our menu, menus (and substitutions) are subject to change due to product availablility.

1. Student's Name: _____ 2. Date of Birth: _____ 3.Grade: ___ 4. School: _____

4. Home Phone # : _____ 5. Daytime Phone # : _____ 6. Other Phone: _____

7.Parent/Guardian Name: _____ Address: _____

Signature: _____ Date: _____

MEDICAL AUTHORITY (MD, PA, NP) PLEASE COMPLETE:

8. Does the student have a disability, medical condition, or severe food allergy/anaphylaxis warranting a diet restriction?

Check one box:

☐ **Yes** If "yes", **STOP** and complete Physician's Rx for Special meals at School

☐ **No** If "no", complete this form

9. Please indicate the Food Allergy or Intolerance and Specific Dietary Request:

10. Suggestions:

- ☐ Lactose Intolerant, may offer water
- ☐ Lactose Intolerant, may offer juice
- ☐ Milk in foods Permitted.
- ☐ Other

11. Medical Authority's Name: _____

12. Registration/License # : _____

13. Medical Authority's Signature: _____

14. Date: _____ 15. Phone # : _____

16. Office Stamp (if applicable):