Dear Parent/Guardian:

Our school records show that your student has a history of a **Life-Threatening Allergy**. The following forms are required each school year for the student to have Emergency Rescue Medication (example – epi pens) in the school's clinic or to self-carry/administer this medication.

1. Life-Threatening Allergy Individual Health Care Plan – Must be completed, signed by the parent/guardian and returned to the school nurse.

2. Authorization for Medication to be Taken During School Hours – Parent/guardian and physician must complete, sign and return to the school nurse.

3. Medical Statement for Children Without Disabilities Requesting Special Needs in School Nutrition Programs (*only required for food allergies)
   - In order for the cafeteria to make dietary substitutions, this form must be completed, signed by the physician and returned to the school nurse. This form then goes to the school's cafeteria manager.

4. Tennessee Department of Education Allergy and Anaphylaxis Emergency Plan. Parent/guardian and healthcare provider must complete, sign and return to the school nurse.

We greatly appreciate your time and effort in completing these forms. This is another step in keeping your child safe while getting the best possible education at school. Please feel free to contact your school nurse if you would like to discuss your student's condition or need help completing these forms.

LIFE-THREATENING ALLERGY INDIVIDUAL HEALTH CARE PLAN

Effective for school year 20___ - 20___ only and MUST be renewed each school year.

This page is to be completed by PARENT/GUARDIAN

Student's Name: _____ **Age:** _____
Teacher: _____ **School:** _____ **Grade:** _____

Parent(s)/Guardian(s) Name and Emergency Contact Information:

Parent/Guardian Name: _____
Phone(_____)_____(Hm/Wk/Cell)
Emergency Contact Name: _____
Phone(____)_____(Hm/Wk/Cell)

List Known Allergies: _____

Please check all that apply:

___Student is aware to avoid allergen
___Student is aware of allergic reaction symptoms?
___Student to always carry emergency kit
___Student **can** self-administer emergency kit
___Notify parent of **ANY** reactions
___Notify parent **ONLY** of **major** reactions
___Notify school nurse of all reactions
___Student is **UNABLE** to self-administer emergency kit

Other instructions/comments: _____
_____

List symptoms of a **MINOR REACTION:** _____
_____

List symptoms of a **MAJOR REACTION:** _____
_____

Medication	Dose	Route	When to Use	How soon can it be repeated
			___Minor ___Major	
			___Minor ___Major	
			___Minor ___Major	

(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)

911/EMS MUST BE NOTIFIED IF AN EMERGENCY KIT IS ADMINISTERED AT SCHOOL

___ I DO ___ I DO NOT request that my child, named above, be permitted to carry and self-administer emergency medication as ordered by the healthcare provider.

___ I understand that the school may suspend or revoke my child's possession and self-administration privileges if he/she misuses the emergency kit or makes it available for usage by another person.

___The secure location (on student's person) where emergency kit will be kept:

___backpack ___sports bag ___purse ___binder OTHER: _____

I, (**print name**) _____ , acknowledge that the school and its employees shall incur no liability as a result of any injury sustained by my child, or any other person, as a result of possession or self-administration of the emergency kit. I shall also indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the emergency kit.

Parent/Guardian Signature: _____ **Date** _____

School Nurse Signature: _____ Date _____

LIFE-THREATENING ALLERGY INDIVIDUAL HEALTH CARE PLAN

Student's Name: _____ School: _____ Date: _____
Please answer the following questions:

1. Is it necessary for school health services to send home a letter notifying your child's classroom about your child's allergy to decrease the chances the allergen will be brought to school by a classmate?
Yes ☐ No ☐

2. Is it necessary for school health services to provide allergy education to classmates and staff?
Yes ☐ No ☐

3. Is it necessary for your student to sit at the allergen-aware table in the cafeteria and classroom**?**
Yes ☐ No ☐

4. Does your student eat school-provided lunch?
Yes ☐ No ☐
If yes, please complete the Special Needs in School Nutrition Program form (CHN-F017) and return to the school nurse.

- Please note without medical documentation on file, the school cafeteria will not monitor your student's food selections.

5. Does your student participate in before or after school sponsored activities such as clubs, or sports programs?
Yes ☐ No ☐
If **yes,** does your student have written physician authorization to self-carry/administer emergency medications on file with the school nurse (form HEA-F062)? Yes ☐ No ☐

- If self-carry is **not** authorized by your Medical Provider, please indicate plan of action for an emergency during a before or after school sponsored event.
  _____
  _____

6. Does your student ride the school bus?
Yes ☐ No ☐
If **yes,** does your student have a written physician authorization to self-carry/administer emergency medications on file with the school nurse (form HEA-F062)? Yes ☐ No ☐

- If self-carry/administration is **not** authorized by a Medical Provider, then 911 will be called for any emergency on the school bus.

7. Does your student require preferred seating on the bus? Yes ☐ No ☐

*The classroom teacher will notify you in advance of parties that will include food or snacks. You may send in allergen-free snacks for your student.
Additional comments/information: _____

Parent/Guardian Signature: _____ **Date:** _____
School Nurse Signature:_____ **Date:** _____
District RN Signature:_____ **Date:** _____

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to and picked up from school by a parent/guardian or his/her adult designee. Children may not bring medication to school or take medication home unless it is an emergency rescue medication that must remain with the student at all times. Prescription Medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose and frequency imprinted on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients.

The following section is to be completed by the PARENT/GUARDIAN:

School:	**Student's Name:**	**Date of Birth:**

I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I also give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

I, _____, will assume any and all responsibility and liability for any problems
Parent/Guardian's Printed Name
with my child taking this medication at school. I release CMCSS and its personnel from any legal claims which they have now, or thereafter have, arising out of medication taken while at school.

_____	_____	(____)_____	(____)_____
Date	**Parent/Guardian Signature**	**Home Phone**	**Emergency Phone**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications

Name of Medication:

Diagnosis for which medication is prescribed:

Route:	**Dose:**

If medication is to be given daily, at what time? (please consider alternate dosing schedule to minimize medication in school)

If medication is to be given "when needed" describe indications:

How soon can it be repeated?	**Length of time treatment recommended?** **___Current School Year ___Other:_____**

List significant side effects:

Provider to initial yes or no for each of the following:
Is student permitted to carry and self-administer emergency rescue medication? _____ **YES** _____ **NO**
Has student been instructed in self administration of prescribed rescue medication? _____ **YES** _____ **NO**

Date **Physician's Signature**

Physician's Name, Address and Phone Number:

Medical Statement for Children Requesting Special Needs in School Nutrition Programs (CHN-F017)

Part I (To be filled out by the School)

Date: _____ *Student's Name*_____ *Grade* _____ *Age* _____

School Name _____ *Teacher* _____

Please return completed form to school nurse.

Federal law and USDA regulation require nutrition programs to make reasonable meal modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences. *Please note that we are not an allergen-free facility; although careful measures are taken to prevent cross-contact, menu items may contain or come into contact with allergens.*

Part II (To be filled out by a State-Recognized Medical Authority*)

Specify the Reason for Request:

☐ Life threatening food allergy (specify): _____

☐ Disability (specify): _____

☐ Other (specify): _____

Describe how the impairment restricts the child's diet (i.e. how the ingestion/contact with the food impacts the child):

Diet Plan: *Indicate food items that must be omitted from school provided meals and list any food substitutions:*

☐ No Milk^ *(No **FLUID** milk as a beverage -Other dairy products and milk as an ingredient/baked in food allowed)*

☐ No Milk/Dairy Products *(All Milk Products & Milk Derivatives, even as an ingredient/baked in food)*

☐ No Yogurt *(Other dairy products and milk as an ingredient/baked in food allowed)*

☐ No Cheese *(Other dairy products and milk as an ingredient/baked in food allowed)*

☐ No Egg *(Eggs as an ingredient/baked in food allowed)*

☐ No Egg/Egg Products *(All Egg Products & Egg Derivatives, even as an ingredient/baked in food)*

☐ No Soy

☐ No Fish

☐ No Gluten

☐ No Peanuts

☐ No Shellfish (Crustacean)

☐ No Tree Nuts

☐ No Wheat

☐ Other (specify): _____

Recommended substitutions: _____

_____

^ *Soy Milk will be substituted when Fluid Dairy Milk is omitted*

Name of State-Recognized Medical Authority* (print) _____

Signature of Medical Authority* _____ ***Date*** _____

*State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Tennessee: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA) with prescriptive authority, Advanced Registered Nurse Practitioner (ARNP) with certificate of fitness, Podiatrist (DPM), and Optometrist (OD), and Dentist (DDS or DMD).

Medical Office Stamp

This institution is an equal opportunity provider.

TN Department of Education

Date of Plan: _____

Allergy and Anaphylaxis Emergency Plan

Student's Name: _____ Date of Birth: _____ Age: ____ Weight: _____ pounds (____ kg)
Student's School System: _____ Student's School: _____
Student has allergy to _____
Student has asthma ☐ Yes (If yes, higher risk for severe reaction) ☐No
Student has had anaphylaxis ☐ Yes ☐No
Student has received instruction and has permission to self-carry epinephrine and use independently ☐ Yes ☐ No

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, use epinephrine.

For **ANY** of the following **SEVERE SYMPTOMS OR A COMBINATION** of symptoms from different body areas

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin, weak pulse, fainting or dizziness
- Tight or hoarse throat, trouble breathing or swallowing
- Swelling of lips or tongue that bothers breathing
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness or agitation
- Repetitive vomiting or severe diarrhea

☐ **SPECIAL SITUATION:** If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

↓

1. Inject epinephrine right away!
Note time when epinephrine was given.

2. Call 911.
- Ask for ambulance with epinephrine.
- Tell rescue squad when epinephrine was given.

3. Stay with Student and:
- Call parents and student's healthcare provider.
- If symptoms get worse or continue after 5 minutes, give a second dose of epinephrine.
- Keep student lying on back. If the student vomits or has trouble breathing, keep child lying on his or her side.

4. Give other medicine (if applicable) following epinephrine
- Antihistamine
- Inhaler/bronchodilator if wheezing

MILD SYMPTOMS

- Itchy or runny nose, sneezing
- Itchy mouth
- Mild nausea or discomfort
- A few hives, mild itchy skin

MONITOR STUDENT

- Stay with student and watch him or her closely.
- Give antihistamine (if listed below).
- Call parents.

If more than 1 symptom or severe allergy anaphylaxis symptoms develop, use epinephrine.

MEDICATION/DOSES

Epinephrine, intramuscular (list type):
_____

Epinephrine Dose: ☐ 0.1 mg
☐ 0.15 mg
☐ 0.3 mg

Antihistamine, by mouth (list type): _____
Antihistamine Dose: _____
Other (e.g., inhaler/bronchodilator if child has asthma):
_____

EMERGENCY CONTACTS

Healthcare Provider: _____
Phone: _____
Parent/Guardian: _____
Phone: _____
Other Emergency Contact Name/Relationship:
_____
Phone: _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date