Dear Parent/Guardian,

Our records indicate that your student has a history of a **Life-Threatening Allergy**. To ensure their safety at school, the following forms must be completed and submitted to the school nurse each year if your child requires emergency rescue medication (ex: epinephrine) at school or will self-carry/administer their medication:

1.Tennessee Department of Education Allergy and Anaphylaxis Emergency Plan: Must be completed and signed by both the parent/guardian and health care provider.

2. Authorization for Medication to be Taken During School Hours (HEA-F062): A separate form must be completed for each medication and signed by the parent/guardian and physician (for prescription medications) to authorize administration during school hours.

3. Medical Statement for Children Requesting Special Needs in School Nutrition Programs (CHN-F017) *(Required for food allergies only)* Signed by medical provider.

4. Life-Threatening Allergy Individual Health Plan: Must be completed and signed by parent/guardian.

We appreciate your time in completing these forms, as they are essential in ensuring your child's safety while they receive the best possible education. Classroom teachers will notify you in advance of any events involving food so that you may provide allergen-free snacks for your child. Additional accommodations, such as allergy-aware cafeteria tables, classroom notifications, and allergy signage, are available upon request.

If you have any questions or need assistance completing these forms, please contact your school nurse.

TN Department of Education

Allergy and Anaphylaxis Emergency Plan

Date of 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

Clarksville-Montgomery County School System
20____ - 20____

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to school by a parent/guardian. Students may not self carry medication at school unless it is an emergency rescue medication that must remain with the student at all times, and is indicated by the prescriber below. 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 on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients. Medications must be picked up by a parent/guardian at the end of the school year or they will be discarded.

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 give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency with 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, and release CMCSS and its personnel from any legal claims arising out of medication taken at school.

_____ _____ _____ (____)_____

Date **Parent/Guardian Name** **Parent/Guardian Signature** **Emergency Phone**

PARENT APPROVAL OF SELF CARRY/SELF ADMINISTRATION OF EMERGENCY RESCUE MEDICATION ONLY (EPI, asthma relief inhaler)
Provider must indicate below and **s**elf-carry privileges may be revoked if the school nurse determines they are misusing the medication, sharing the medication, or found incapable of properly administering.
Parent intitial for emergency rescue medication only: _____ I DO _____ I DO NOT request my child be permitted to self carry and self administer emergency medication as ordered by the healthcare provider.

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 *for emergency rescue medications only:* *(EPI, relief inhalers)*
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:

Clarksville-Montgomery County School System
20____ - 20____

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_____ _____ _____ (____)_____

Date **Parent/Guardian Name** **Parent/Guardian Signature** **Emergency Phone**

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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 *for emergency rescue medications only:* *(EPI, relief inhalers)*
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 Sesame

☐ 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, Registered Dietitian (RD), Podiatrist (DPM), and Optometrist (OD), and Dentist (DDS or DMD).

Medical Office Stamp

This institution is an equal opportunity provider.

LIFE-THREATENING ALLERGY HEALTH PLAN

School Year 20___ - 20 ___

Student's Name: _____School: _____ Grade: _____ Teacher: _____

Parent/Guardian Input:

List Life-Threatening Allergen(s):_____

☐ Student is aware to avoid allergen	☐ Student is aware of symptoms of an allergic reaction
Does your student ride the school bus? ☐ Yes ☐ No	Bus # _____
Does your student eat school provided lunch? ☐ Yes ☐ No	Form CHN-F017 must be signed by the physician and returned to the school nurse/cafeteria manager in order to receive substitutions. *Indicated for severe food allergies only, not preferences.
HEA-F062 Authorization for Medication at school must be completed for **each** medication	
***Location of emergency epinephrine (backpack, purse, nurse clinic):** _____	

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

For School Nurse Only:

- ☐ Emergency Medication on the School Bus Form sent to Transportation (bus riders only)
- ☐ Child Nutrition Form sent/ on file with Cafeteria Manager
- ☐ Student demonstrated competency & proficiency in proper self-administration of emergency epinephrine.

Nursing Diagnoses: Risk for allergy response related to exposure to allergen.

- Risk for ineffective airway clearance related to bronchoconstriction, and excessive mucus.
- Risk for knowledge deficit regarding early signs and symptoms of an allergic reaction, prescribed medical treatment and management of anaphylaxis.
- Other: _____

Nursing Interventions: The School Nurse will:

- Educate school staff on early warning signs and symptoms of allergic reactions and potential anaphylaxis
- Train staff who volunteer on proper use of epinephrine and document yearly training
- Administer medications as ordered by the healthcare provider
- Other: _____

Expected Outcomes: The Student will:

- Recognize allergen and prevent exposure to prevent allergic reaction
- Inform staff immediately if having issues with swallowing, breathing, nausea, cramping, or other symptoms that may indicate an allergic reaction
- Understand and verbalize signs and symptoms of a severe allergic reaction or anaphylaxis

Additional comments:

_____

_____

Parent Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____