REGIONAL SCHOOL DISTRICT NO. 16

BEACON FALLS AND PROSPECT

Prospect Elementary. Laurel Ledge Elementary. Long River Middle School. Woodland Regional High School

Dear Parent/Guardian,

You have indicated that your child has a food allergy. In order for us to better accommodate his/her needs, it will be necessary for you to fill out the attached forms. Please take the time to read each form carefully.

We will also appreciate the following:

- To enable staff to easily recognize your child please email a recent photo to the school nurse. If your child had their picture taken in school last year I will not need a photo as I can retrieve it from the school server. The pictures will be available in the teacher's sub folder, in a folder for cafeteria staff and in the Nurse's sub folder for quick and easy identification.
- The enclosed Food Allergy Action Plan must be completed by you and your child's physician. Please note that for a student with multiple food allergies, separate forms must be used; one for each allergy. One form is enclosed. If more than one is needed, please contact the school or make copies as needed
- If medications are prescribed on the enclosed authorization forms (EpiPens and/or Benadryl, etc.), these must be delivered to the school by a **responsible adult**. The enclosed forms must be filled out and signed by you and the doctor. This medication is kept in the Health Office. Medication forms are also available at the region's website, www.region16ct.org under district resources… general information… forms.
- Instructions regarding school lunches must be signed by parent/guardian and sent back to the school nurse unless you checked off #1. In that case please contact our Food Service Director, Vicki Biello at 203-758-6671 for instructions. You must have all documentation signed and in place before your child can participate in our school lunch program.

Your prompt attention to these matters is appreciated so that we can implement a personalized health management plan. Do not hesitate to call if you have health concerns you would like to discuss with the school nurse, the classroom teacher, or additional school staff.

Sincerely,
The Region 16 Nursing Staff

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SCHOOL LUNCH PROGRAM/PARENT RELATIONSHIP

FEEDING SCHOOL LUNCH MEALS TO STUDENTS WITH LIFE-THREATENING FOOD ALLERGIES

P ARENT'S R ES P ONS IB ILIT IES

1. Current authorized Medical Statement for Students with Disabilities Requiring Special Meals in the Child Nutrition Program must be on file.
2. Parent of medically approved child may choose up to five lunch choices from the menu that must be adhered to throughout the school year.
3. The parent will choose these items from the school lunch menu and the attending physician will review, approve and sign the menus or the clause in the medical statement.
4. The parent is responsible for reading the ingredient labels of the selected products. The parent must initial the approved products. When the products are reordered, the parent must visit the kitchen site to approve and initial newly delivered items.
5. By signing the agreement, the parent acknowledges the possible, but not probable risks the allergic child may incur when participating in the school lunch program and agrees to follow the steps as listed above.

S C HOO L LU NCH D IR ECTOR AND S TAF F'S R ES P ONS IB ILIT IES

1. The School Lunch Director will discuss menu options and items for the student with the parent. The director and parent will agree upon the menu items.
2. The School Lunch Director will inform the kitchen staff of the choices in the form of a physician approved written menu and notify the teacher.
3. The Site Manager will order the requested food and contact the parent upon arrival.
4. The approved, initialed products will be kept in a separate storage area/container with the student's name clearly written on it.
5. A separate written menu will be available for the child each time the child eats the chosen school lunch. NO EXCEPTIONS to the menu will be made at any time or for any reason.
6. The school lunch director and the site manager will instruct the school lunch staff on the proper procedure for the storage, handling and serving of the approved products to the allergic student.
7. By signing this agreement, the School Lunch Director agrees that she will follow the steps listed above.

Parent/Guardian Signature_____

Printed Name _____ Date _____

Director of Child Nutrition Signature _____

Printed Name _____ Date _____

MEDICAL STATEMENT FOR CHILDREN WITH DISABILITIES
REQUIRING SPECIAL MEALS IN CHILD NUTRITION PROGRAMS

Part 1 (To be filled out by School)
Date: _____ Name of Child: _____

School Attended by Child: _____

Part 2 (To be filled out by Physician)
Patient's Name: _____ Date: _____

Diagnosis: _____

_____

_____

_____

Describe the patient's disability and the major life activity affected by the disability: _____

_____

_____

Does the disability restrict the individual's diet? ☐ Yes ☐ No
If yes, list food(s) to be **omitted** from the diet and/or foods to be **substituted** (Diet Plan with parent approved menus must be attached. Physicians must review menus with parent and sign.):

_____

_____

_____

_____

List food(s) that require a change in texture:

Cut up or chopped to bite-size pieces: _____

_____

Finely ground: _____

_____

Pureed: _____

_____

Special Equipment Needed: _____

_____

_____ _____

Date Physician

FOOD ALLERGY ACTION PLAN

Place Child's Picture Here

ALLERGY TO: _____

Student's Name: _____ D.O.B.: _____ Teacher: _____

Asthmatic Yes* ☐ No ☐ * High risk for severe reaction

☛Signs of an Allergic Reaction☚

Systems	Symptoms
MOUTH	Itching & swelling of the lips, tongue or mouth
THROAT*	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG*	Shortness of breath, repetitive coughing and/or wheezing
HEART*	"Thready" pulse… "passing-out"

The severity of symptoms can quickly change.
***All above symptoms can potentially progress to a life-threatening situation.**

☛Action for Minor Reaction☚

1. If only symptom(s) are: _____, give _____ _____(medication/dose/route)

Then call:

2. Mother _____ Father _____, or emergency contacts:
   Relationship/Name/Phone: _____
   Relationship/Name/Phone: _____
   Relationship/Name/Phone: _____
3. Dr. _____ at _____.

If condition does not improve within 10 minutes, follow steps for **major reaction** below.

☛Action for Major Reaction☚

1. If ingestion is suspected and/or symptoms(s) are:_____, give _____(medication/dose/route) IMMEDIATELY!

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother, Father, or emergency contacts listed above.
4. Dr. (listed above).

DO NOT HESITATE TO CALL EMERGENCY SQUAD!

Parent Signature _____ Date _____

Doctor's Signature _____ Date _____

For children with multiple food allergies, use one form for each food.

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1._____ Relation: _____ Phone: _____ 2._____ Relation: _____ Phone: _____ 3._____ Relation: _____ Phone: _____	1._____ Room Extension:_____ 2._____ Room Extension:_____ 3._____ Room Extension:_____ 4._____ Room Extension:_____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

(For certified/trained personnel only!)

1. **Pull off gray activation cap.**
2. **Hold black tip near outer thigh (always apply to thigh).**
3. **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.**
4. **Call EMS and transport.**

REGIONAL SCHOOL DISTRICT NO. 16

INSTRUCTIONS REGARDING SCHOOL LUNCH PARTICIPATION FOR CHILDREN WITH LIFE-THREATENING FOOD ALLERGIES

Dear Parent/Guardian: Please check the appropriate statements below, sign and date this document.

If you have checked clause one, please follow the instructions listed below it.

If you have checked off clause two or three, please sign this form and return it you your school nurse.

1. _____ I agree to have my child participate in the school lunch program according to Regional School District No. 16 Food Allergy Policy.

*If you checked No. 1, you **must** make an appointment with the Food Service Director by calling (203) 758-6671 for a copy of the Medical Statement and to choose menu items and review policy information*.

2. _____ I give my child permission to participate in the school lunch program as per my instructions. I do not wish to file the signed Medical Statement for Children with Disabilities Requiring Special Meals in the Child Nutrition Program and the Regional School District No. 16 Food Allergy Policy document.

3. _____ I do not wish my child to participate in the school lunch program at any time during the school year.

During lunch, the cafeteria has a **nut free table** where children who have food allergies can sit. Please indicate where you would like your child to sit:
_____My child may sit at the peanut free table with other students who have food allergies.
_____My child may sit with his or her class at the assigned table.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Print Name

_____ _____
Child's Name Child's Teacher/Grade

REGIONAL SCHOOL DISTRICT NO. 16
BEACON FALLS/PROSPECT

SNACKS/PARTIES/TREATS
(CHILDREN WITH REPORTED FOOD ALLERGIES)

Child's Name: _____

Allergies that are noted on the health file: _____

_____

Dear Parent:

Please fill out this form in regards to your child being able to participate in food being offered in the classroom. This must be returned to the School Nurse in order for your child to participate in these events.

☐ My child will be allowed to participate in school parties and birthday parties, and can eat/drink what is provided.

☐ I want to be notified by the teacher of foods/drinks that are being offered in his/her classroom at these events.

☐ Parent will provide a supply of safe snacks/party foods to be kept on hand at school for their child. These are the only snacks the child will consume at celebrations.

Parent Signature: _____ Date: _____

Child's Teacher: _____ Grade: _____

If you wish to be notified, please provide phone numbers where you can be reached. If we are unable to reach you, your child will not be allowed to have the food/drink that is being offered.

HOME: _____

WORK: _____

CELL: _____

Thank you for your cooperation in this matter.
Regional School District No. 16 Nursing Staff

REGIONAL SCHOOL DISTRICT NO. 16

CHECKLIST FOR FILING MEDICAL STATEMENT

FOR CHILD WITH FOOD ALLERGIES REQUIRING SPECIAL MEALS

☐ 1) Review instructions regarding school lunch in the child's allergy packet.

☐ 2) Parent/Guardian schedule an appointment to meet with Food Service Director to review the required Medical Statement and to select the desired menu choices. (The Medical Statement must be signed by the child's physician annually.)

☐ 3) Parent/Guardian visits the kitchen site to review and initial the desired food items. The food is placed in storage for the child.

☐ 4) Parent/Guardian takes Medical Statement to the physician to fill out and sign.

☐ 5) Return the signed Medical Statement to the Food Service Director.

☐ 6) The Director and the Parent/Guardian sign and date the policy agreement.

☐ 7) The Director will send copies of the menu selections to the School Lunch Manager and the child's Teacher.

☐ 8) For students new to the school, Parent/Guardian provides a picture of the child to the School Nurse.

☐ 9) Parent/Guardian provides Food Allergy Action Plan (please fill out separate forms for each food item) and signed documentation from the child's physician regarding the food that causes sensitivity and outlining the steps to be taken in the event of exposure/ingestion.

☐ 10) If prescribed by physician, EpiPens or other medication must be delivered to the School Nurse by a responsible adult along with the signed AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL form(s).

☐ 11)Child may begin participating.

QUESTIONNAIRE FOR PARENTS OF CHILD WITH ALLERGIES

Student's Name _____ School Year _____

School _____ Grade _____ Teacher _____

Parent's Name(s) _____

Phone _____ home _____ work _____ cell

Name of Child's Doctor (for allergy) _____ Phone _____

The following information is helpful to your child's School Nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the School Nurse, please call for an appointment.

1. What are your child's allergies? _____

2. Please rate the severity of his/her allergy/allergies. (circle)

   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. What type of reaction does your child have? (Please be specific)

   _____ upset stomach _____ headache _____ hives _____ diarrhea

   _____ swelling _____ wheezing _____ difficulty breathing

   _____ other (please describe)_____

4. What medical interventions are needed? _____

5. Please list the medication your child takes for allergies (everyday and/or as needed)

	Name of Medication	Dose	Frequency
(In School)			
(At Home)			

If medications are to be given during school, a medication permission slip (there are separate slips for over the counter and for prescription medications) needs to be filled out yearly. Medications must be in the original container. Prescription medications must have the pharmacist's label. Please label over the counter medical with the child's name. When you get prescriptions filled you can ask the pharmacist to put them into two containers so you will have one for school and one for home use.

6. If your child does not respond to the medication, what action do you advise school personnel to take? _____

   _____

7. What, if any, side effects does your child have from his/her medication? _____

   _____

(OVER)

8. Has your child ever been hospitalized for an allergic reaction? _____

_____

9. Has your child ever been treated in the emergency room for an allergic reaction? _____

_____

10. How often does your child see his/her doctor for routine allergy evaluation? _____

_____

11. Does your child need any special considerations related to his/her allergy while at school? (Check any that apply and describe them briefly)

    Avoid certain foods _____

    No animal pets in classroom _____

    Special consideration while on field trips _____

    Special considerations regarding hot lunch _____

    Special considerations during school parties _____

    Observation from side effects from medication _____

    Other _____

    _____

Parent/Guardian Signature _____

Date _____

Thank you for your time and assistance in assessing your child's special needs in school. For more information please contact your school nurse directly.