Campus_____ Attach Photo Here

Northside Independent School District
2012-2013
Food Allergy/Special Dietary Needs/Disability Action Plan
Physician Order Form

Name: _____ Student ID #: _____ D.O.B. ___/___/____ Wt: _____lbs

Life Threatening Food Allergy / Special Dietary Needs / Disability: _____

1. Omit these foods: ___ milk/dairy ___ peanuts/tree nuts ___ eggs ___ fish/shellfish ___ wheat ___ soy
   Other _____

2. Can the student consume foods where the allergen is an ingredient in the food product? ___ yes ___ no
   (*Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed, fluid milk is omitted but milk as an ingredient is allowed*) Explain_____

3. Major life activity affected by the life threatening food allergy or disability (check all that apply):
   ___eating ___caring for one's self ___ performing manual tasks ___ walking ___ seeing ___ hearing
   ___speaking ___breathing ___ learning

4. Foods to Substitute or Modify (A l*ist of substitutions is required. A marked menu from parent/guardian signed by medical authority may be required.)* _____

Information regarding Northside ISD nutritional programs may be found on the Child Nutrition website http://childnutrition.nisd.net. Information provided by the district on its website or by school cafeteria managers/staff is not intended as a substitute for advice from your physician or other healthcare professional. Parents are welcome to review ingredient labels and/or recipes and may do so by contacting the Director of Child Nutrition Services at 210-397-4512. It is the policy of Northside ISD not to discriminate on the basis of age, race, religion, color, national origin, sex or disability in its programs, services or activities.

Medications/Doses
Epinephrine (brand and dose): _____
Antihistamine (brand and dose): _____
Is the student asthmatic? ___yes ___ no Bronchodilator (brand and dose): _____

Treatment Plan: Physician to check appropriate medication(s)

Food allergen ingested – no symptoms	___ Epinephrine ___ Antihistamine
Respiratory – wheezing, shortness of breath, coughing	___ Epinephrine ___ Antihistamine
Cardiovascular –low blood pressure, weak pulse, pallor/blue	___ Epinephrine ___ Antihistamine
GI – nausea, vomiting, diarrhea, cramping	___ Epinephrine ___ Antihistamine
Skin – hives, itching, rash, swelling of face/extremities	___ Epinephrine ___ Antihistamine
Mouth – swelling lips/tongue, itching, tingling	___ Epinephrine ___ Antihistamine
Throat – tightening, hoarseness, coughing	___ Epinephrine ___ Antihistamine
Other - _____	___ Epinephrine ___ Antihistamine
Symptom Worsening - _____	___ Epinephrine ___ Antihistamine

Parent consents for nurse follow up with physician? ___ yes ___ no _____ _____
Parent Signature Date

Physician recommendations for medication self-administration: (Initial one)
____ The student above has been instructed by me in the proper way to use his/her medication(s). It is my professional opinion that he/she be allowed to carry and self –administer the above medications while on school property or at school related events.
____ The student above in my professional opinion should NOT be allowed to carry and self-administer any of the above medication(s) while on school property or at school related events.

_____ _____
Physician Signature / Phone # **Date**

Northside Independent School District
Health Services Department
Emergency Kit Procedures Form: Insect Sting or Allergy

The Northside Independent School District will allow the school nurse to administer emergency injections to the student involved if there is a known hypersensitivity and the emergency kit is on campus. The child may give his/her own injection, in the absence of the nurse, if the student has been taught.

Other campus personnel, previously identified as capable of giving injections, will give the emergency injection if the nurse is absent and the child cannot give it to him/her self.

The school nurse will follow physician orders received for each student and administer emergency medications as written. The child who has an allergic reaction with an unknown trigger will be observed and treated by NISD staff per orders received after communicating with the NISD medical consultant.

The Northside Independent School District can give the emergency medications, as outlined above, if the following form is completed by the child's physician.

Must be filled out and signed by physician and parent/guardian.

Name_____ Age_____ Sex F M

Allergic to _____

The following steps will be followed as ordered by private physician or NISD medical consultant:

1. Give injection of epinephrine (dose) _____.
2. Give _____orally at once.
   Medication and dose

1. Call **parent/guardian** or **EMS**.
2. Remove stinger if present.
3. Use ice pack over site.
4. Make arrangements to have student transported to emergency room or doctor's office.
5. Give second dose of epinephrine after 30 minutes if child is still on campus.

Date_____ _____
Signature of Physician

_____
Signature of Parent/Guardian

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2 years

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