Red Clay Consolidated School District

ADMINISTRATIVE MEMORANDUM

To: School Employees

From: Mervin B. Daugherty, Ed.D.
Superintendent

Subject: Guidelines for Managing Students with Food Allergies

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The district recognizes the growing number of students who attend our schools with a potentially life-threatening food allergy. We are committed to providing a safe environment for all students and to minimizing the risk of accidental exposure in the school setting.

Managing food allergies is a shared responsibility among families, schools, students, and healthcare providers. This administrative memorandum provides guidelines for managing students with food allergies, with a focus on promoting awareness education, prevention, communication, and emergency response.

Family's Responsibility

1. Notify the school nurse of the child's food allergy.

2. Provide written medical documentation, instructions, and medications in the Food Allergy Action Plan (FAAP) (attached), as directed by a physician at the start of each school year. Include a photo of the child on the FAAP.

3. Provide properly labeled emergency medications to the school nurse and replace medications upon use or expiration.

4. Provide a Statement for Special Diet Prescription (attached) completed by a licensed physician for students with a life-threatening food allergy who will participate in the school meals program.

5. Educate the child in the self-management of their food allergy including (a) safe and unsafe foods, (b) symptoms of an allergic reaction, (c) how and when to tell an adult they may be having an allergic reaction, and (d) no food or utensil sharing.

6. Review policies and procedures with the school staff, the child's physician, and the child after an allergic reaction has occurred.

7. Provide up-to-date emergency contact information.

School's Responsibility

1. *School nurse:* Review health records submitted by parents and health care providers.

2. *School nurse:* Share the FAAP with appropriate staff including, but not limited to, teachers and the nutrition supervisor.

3. Provide annual staff training on the basics of food allergy including the signs and symptoms of an allergic reaction, what to do in an emergency, and strategies to eliminate food allergens in the allergic student's meals, educational tools, arts and crafts projects and incentives. Staff must complete this training through PD 360.

4. Designate a "safe zone" in the cafeteria to accommodate the needs of students with food allergies.

5. *Office of Nutrition Services:* Provide allergen-appropriate meals to students with life-threatening food allergies who have submitted a Statement for Special Diet Prescription completed by a licensed physician.

6. Enforce a "no eating" policy on school buses with exceptions made only to accommodate students with special needs under federal laws.

7. Encourage the use of nonfood items for classroom parties and celebrations by raising awareness of food allergy in the school community. (See attached sample letter to parents in an elementary homeroom.)

8. Provide reasonable advance notice to families of children with food allergies of classroom celebrations, field trips, and other special events where food is involved. Coordinate efforts with the families to ensure that food is safe and that students with food allergies are fully included in school activities.

9. Reduce the risk of accidental exposure to food allergens at school. All food products distributed or sold in school during regular school hours are required to have a commercial ingredient label for allergen identification. Food products distributed by the Office of Nutrition Services are screened for food allergens by their department and do not require an ingredient label.

Student's Responsibility

1. Should be proactive in the care and management of their food allergy, according to their developmental level.

2. Should not trade or share food or utensils with others.

3. Should not eat anything with unknown ingredients or known to contain a food allergen.

4. Immediately notify an adult if they eat something they suspect may contain a food allergen.

Questions about the information contained in this administrative memorandum should be directed to the Manager of RTTT and Compliance.

Authorizing Code(s):	Red Clay Consolidated School District Board of Education Policy 8001
Office(s) Responsible:	Superintendent
Last Issued:	04/30/2012
Last Revised:	Not applicable
Attachment(s):	Food Allergy Action Plan (FAAP) (English) Food Allergy Action Plan (FAAP) (Spanish) Statement for Special Diet Prescription Sample Letter to Parents

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**

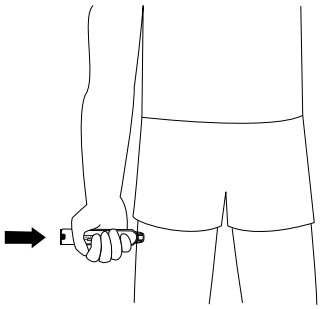
TURN FORM OVER

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**

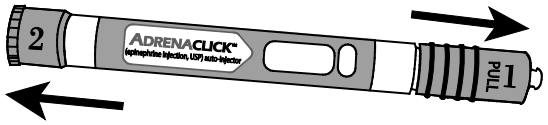
- **Hold orange tip near outer thigh (always apply to thigh)**



- **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

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: (___) _____-_____

Plan de Acción en Alergia a Alimentos

Plan de Emergencia

Nombre:_____ **Fecha de Nacimiento:** ___/ /___

Alergias: _____

Peso: _____ Kg./lbs. **Asma:** ☐ Sí (mayor riesgo de reacción severa) ☐ No

Ponga la foto del estudiante aquí

Extremadamente sensible a los siguientes alimentos:

COMO PROCEDER: _____

☐ Administrar Epinefrina inmediatamente ante CUALQUIER síntoma que se presente si se sospecha de haber ingerido el alergeno.

☐ Administrar Epinefrina inmediatamente si se confirma la ingesta del alergeno, aunque no se presente ningún síntoma.

SINTOMAS SEVEROS tras haber ingerido un alergeno:

Uno o más de los siguientes:

PULMON: Falta de aire, sibilancias, tos repetitiva

CORAZON: palidez, cianosis (coloración azul de la piel), desmayo, pulso débil, mareo, confusión.

GARGANTA: ardor, dificultad para tragar o respirar.

BOCA: inflamación obstructiva (lengua y/o labios)

PIEL: sarpullido - reacción alérgica en la piel

O **la combinación** de síntomas en diferentes partes del cuerpo:

PIEL: urticaria/ronchas, picor, sarpullido, inflamación (ej: ojos, labios)

ESTOMAGO: vómito, dolor

1. **INYECTAR EPINEFRINA INMEDIATAMENTE**
2. Llamar al 911
3. Comenzar seguimiento del paciente (ver indicaciones abajo)
4. Administrar medicamentos adicionales:*
   a. Antihistamínicos
   b. Broncodilatador inhalado, en caso de asma

*Los antihistamínicos & inhaladores/broncodilatadores no están indicados para el tratamiento de una reacción alérgica severa (anafilaxia). USAR EPINEFRINA

SINTOMAS LEVES SOLAMENTE:

BOCA: picor en boca

PIEL: sarpullido alrededor de la boca o cara, picor leve

ESTOMAGO: náuseas leves, malestar general

1. **ADMINISTRAR ANTIHISTAMINICO**
2. Permanecer con el estudiante; alertar a un médico y avisar a los padres.
3. Si los síntomas progresan (ver arriba), USAR EPINEFRINA
4. Comenzar seguimiento (ver indicaciones abajo)

Medicación/Dosis

Epinefrina (marca y dosis): _____

Antihistamínico (marca y dosis): _____

Otro (por ej., inhalador-broncodilatador si es asmático): _____

Seguimiento

Permanecer con el estudiante; alertar a un médico y a los padres. Comunicar al personal de emergencias que se le administró epinefrina; Pedir una ambulancia que cuente con epinefrina; Anotar la hora en que se administró la epinefrina. Se puede administrar una segunda dosis de epinefrina a los 5 minutos o más de la primera dosis en caso de que los síntomas persistan o reaparezcan. En caso de reacción severa, procurar mantener al estudiante acostado boca arriba con las piernas levantadas. Se debe administrar la medicación aunque no se pueda contactar con los padres. Ver modo de administración del autoinyector al reverso/detrás.

_____ _____ _____ _____

Firma de los padres **Fecha** **Firma del médico** **Fecha**

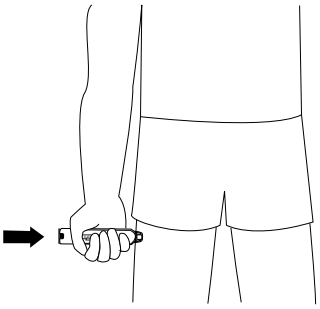
Dé la vuelta al documento

Documento proporcionado por cortesía de FAAN (www.foodallergy.org) 2/2012

Como aplicar el EpiPen Auto-inyector y el EpiPen Jr Auto-inyector

1. **Primero, saque el EpiPen Auto-inyector del estuche de plástico donde está guardado.**
2. Quite la tapa de seguridad azul

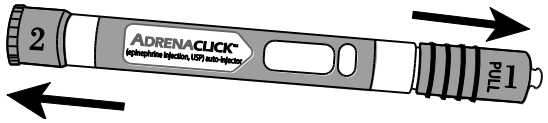
3. Sostenga el EpiPen con la punta naranja cerca de la parte externa del muslo (siempre aplicarlo en el muslo)

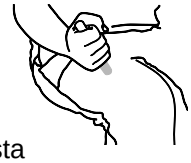


4. Aplique clavando enérgicamente la punta naranja contra el muslo. Manténgalo contra el muslo durante aproximadamente 10 segundos. Retire el EpiPen Auto-inyector y dé un masaje en la zona durante otros 10 segundos.

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Pasos para aplicar Adrenaclick™ 0.3 mg y Adrenaclick™ 0.15 mg





Quitar las dos tapas **GRISES** marcadas como “1” y “2”.

Colocar la punta redonda **ROJA** en la parte externa del muslo, presionar con fuerza hasta que penetre la aguja. Mantener 10 segundos, luego retirar.

Un Kit de tratamiento de emergencia ante reacciones alérgicas debe siempre contener al menos 2 dosis de epinefrina, otros medicamentos indicados por el médico del estudiante y una copia de su plan de acción ante reacciones alérgicas alimentarias.

El kit debe acompañar al estudiante si sale de la escuela (ej: viaje/excursión escolar).

Contactos

Llamar 911 (Servicio de Urgencias: (___)_____-_____) Médico:_____Número de teléfono: (___)_____-_____

Padres:_____ Número de teléfono: (___)_____-_____

Otros contactos en caso de emergencia:

Nombre/Relación: _____ Número de teléfono: (___)_____-_____

Nombre/Relación: _____ Número de teléfono: (___)_____-_____

Statement for Special Diet Prescription - Delaware Department of Education-School Nutrition Programs

The following child is a participant in one of the United States Department of Agriculture (USDA) programs: National School Lunch Program, School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physicians/medical authority would be made. The statement must include the following:

Part 1: To be completed by Parent/Guardian

Child's Name:	Date of Birth: M F
Name of School/Center/Program:	Grade Level/Classroom:
Parent's/Guardian's Name: ( ) ( ) Home Phone Work Phone Address:	In accordance with the provisions of the health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____(doctor's name) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to_____ and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information will expire on _____. Parent/Guardian Signature: _____ Date: _____

Part 2: To be completed by Physician/Medical Authority

Does the child have a disability? Yes _____ No _____ If Yes, please describe the major life activities affected by the disability.		Does the child have special nutritional or feeding needs? Yes _____ No _____ If yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.
If the child is not disabled, does the child have special nutritional or feeding needs? Yes _____ No _____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.		Does the child require emergency medication be administered? Yes _____ No _____ If Yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by Physician/Medical Authority

List any dietary restrictions or special diet:

List any food allergies or food intolerances:

Delaware Department of Education-School Nutrition Programs Statement for Special Diet Prescription Pg2

List foods or beverages to be substituted (**mandatory**):

Added by Red Clay School Nutrition Services: For milk allergies, please list specific beverage alternatives (i.e.- soy milk):

List foods that need te following change in texture. If all foods need to be prepared in this manner, indicate "All.'

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number:		Office Stamp
Physician's/Medical Authority Signature:		Date
Part 4: Parent/Guardian's Signature		Date
Part 5: Program Signature		
School/Program Official Signature		Date

*Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Sample Letter for Elementary School Homeroom

Date

Dear Parents/Guardians in Homeroom_____
A student in your child's class has a food allergy to (Peanuts, Tree Nuts, Wheat, Soy, Milk, Eggs, Fish, Shellfish, _____). Nearly 6 million or 8% of children have food allergies in the United States. Food allergy can be potentially fatal and there is no cure. The only way to avoid an allergic reaction is to avoid the offending food.

We know that many parents like to celebrate birthdays or other occasions with special treats. We encourage parents to celebrate with nonfood items such as stickers, pencils, and themed erasers, rather than food. **Any food sent in to share with students must be prepackaged and contain a commercial ingredient label.** Please give these items to your child's teacher for distribution. Advise your child not to share or trade food with their classmates.

To learn more about food allergy, please visit The Food Allergy & Anaphylaxis Network's website at www.foodallergy.org.

Thank you for your cooperation in keeping all our children safe. We look forward to a great school year!

Sincerely,

School Nurse