
SECTION 5

SAMPLE FORMS

This section of the guidelines offer various sample forms and tools districts may use to provide for the care of students with life-threatening food allergies. The forms are samples. School districts are encouraged to modify the forms to incorporate district and student specifics as needed. The following forms are available:

- Sample Student Health Registration Form
- Sample Food Allergy Assessment Form
- Sample Bee or Insect Allergy Assessment Form
- Sample Authorization for Administration of Medication at School
- Sample Authorization for Exchange of Medical Information
- Sample LHCP Letter Regarding Unlicensed Staff Administering Emergency Medication at School
- Sample Children with a Life-Threatening Food Allergies Diet Prescription Form
- Sample Children with Special Dietary Needs Diet Prescription Form
- Sample Life-Threatening Allergy Care Plan
- Sample Training Program
- Pre-Assessment for Allergy and Anaphylaxis Training
- Sample Allergy and Anaphylaxis Training Assessment
- Evaluation for Allergy and Anaphylaxis Training
- Sample EpiPen® Training for School Staff
- Sample Emergency EpiPen® Medication Administration at School Skills Checklist
- Sample Registered Nurse Checklist for Students with Life-Threatening Food Allergies
- Sample Sack Lunch Request Form
- Sample Substitute Teacher Letter
- Sample Classroom Letter
- Sample School Letter to All Parents
- Sample WASSDA Policy
- Sample WASSDA Procedure

Student Health Registration Form

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

Student Name _____ Grade _____ Sex _____ Date of Birth _____

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No ___

Name of child's doctor or nurse practitioner _____ phone number _____

In the past 12 months, did you have problems obtaining medical care for your child? Yes ___ No ___

DENTAL

Does your child have a dentist? Yes ___ No ___ Name of child's dentist _____ phone number _____

Did your child receive a dental exam in the last 12 months? Yes ___ No ___ Don't know ___

Describe the condition of your child's teeth? Good ___ Fair ___ Poor ___ Don't know ___

In the past 12 months, did you have problems obtaining dental care for your child? Yes ___ No ___

INSURANCE

Does your child have medical insurance coverage? Yes ___ No ___ Don't know ___ Name of provider _____

Does your child have dental insurance coverage? Yes ___ No ___ Don't know ___ Name of provider _____

Does Medicaid insure him/her? (Apple Health for kids) Yes ___ No ___ Don't know ___

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___ Asthma ___ Seizure disorder ___ Bleeding disorder ___ ADD/ADHD
___ Diabetes ___ Bone/muscle disease ___ Skin condition ___ Learning disability
___ Heart condition ___ Mental health condition (i.e., depression, anxiety, eating disorder) ___ Other _____

Does your child experience any of the following?

___ Nose bleeds ___ Frequent ear aches ___ Overweight for age ___ Physical disability
___ Poor appetite ___ Frequent stomach aches ___ Frequent headaches ___ Fainting spells
___ Tires easily ___ Emotional concerns ___ Underweight for age ___ Other _____

Do any of the above condition(s) limit/affect your child at school? _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes * ___ No ___ Describe: _____

***If yes, a meeting with the school nurse is required. Washington State Law requires medication or treatment orders and a health care plan be in place prior to starting school.**

ALLERGIES

Plants ___ Animals ___ Food ___ Molds ___ Drugs ___ Bees ___ Other _____

Please describe the allergic reaction and the treatment for **each** checked allergy _____

Do you plan for your child to receive school prepared meals? Yes * ___ No ___

*an additional form must be completed for food allergies

MEDICATION

Does your child take any medication? Yes ___ No ___ If yes, name of medication: _____

Purpose _____ Will medication be needed at school? Yes* ___ No ___

***If your child needs to take medication at school, please contact the office for the necessary authorization form. This form must be completed prior to any medication being brought to school.**

HEARING/VISION

Do you have concerns about your child's hearing? Yes ___ No ___ Does your child wear hearing aides? Yes ___ No ___

Do you have concerns about your child's vision? Yes ___ No ___ Does your child wear glasses or contacts? Yes ___ No ___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes ___ No ___ Do others have difficulty understanding your child?

Yes ___ No ___ If yes, please explain _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____

Adapted with permission from Mount Baker School District

Food Allergy Assessment Form

Student Name: _____ Date of Birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating food allergy: _____ Phone: _____

Do **you think** your child's food allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible).

Did your student's **health care provider tell you** the food allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish/shellfish | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) | |

Please list any others: _____

How many times has your student had a reaction? Never Once More than once, explain: _____

When was the last reaction? _____

Are the food allergy reactions: staying the same getting worse getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

Eating foods Touching foods Smelling foods Other, please explain: _____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

No Yes, explain: _____

Does your student understand how to avoid foods that cause allergic reactions? Yes No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? No Yes

Does your student know how to use the treatment? No Yes

Please describe any side effects or problems your child had in using the suggested treatment: _____

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

- Yes.
- No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

- Yes.
- No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

- Yes.
- No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods? _____

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

- Yes.
- No.

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

Bee or Insect Allergy Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating bee allergy: _____ Phone _____

Do **you think** your student's bee allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible.)

Does your student's **health care provider think** the bee allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible.)

History and Current Status

What type of stinging bee or insect has your student reacted to? _____

How many times has your student had a reaction? Never Once More than once, please describe:

When was the last reaction? _____

Are the reactions: staying the same getting worse getting better

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction? No Yes, please describe: _____

Has your student ever received or used an EpiPen® or other injection as treatment? No Yes, please describe: _____

Triggers and Symptoms

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things your child might say.)*

How quickly do the signs and symptoms appear after the sting? ___ seconds ___ minutes ___ hours ___ days

Treatment

Does your student understand how to avoid getting a bee sting or insect bite? Yes No

What do you do at home if there is a reaction to a bee sting or insect bite? _____

What treatment or medication has your health care provider recommended for an allergic reaction? _____ None

Have you used the treatment or medication? No Yes

Does your student know how to use the treatment or medication? No Yes

Please describe any side effects or problems your student had in using the suggested treatment or medication.

If medication is to be available at school, have you filled out a medication form for school?

Yes

No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication or treatment supplies to school?

Yes

No, I need to get the medication/treatment and bring it to school.

What do you want the school to do in case of a bee sting or insect bite? _____

Parent/Guardian Signature: _____ Date: _____

Adapted with permission from ESD 171 SNC Program

Authorization for Exchange of Medical Information

SECTION I – INFORMATION REQUESTED FROM		
NAME:	NAME OF PERSON DISCLOSING INFORMATION:	
AGENCY:		
ADDRESS: _____ _____	TITLE:	
Name of Student:	Birth Date:	Date:
Specific nature of information to be disclosed: _____ _____ _____ _____		
SECTION II – AUTHORIZATION		
<p>I hereby authorize the release of medical information as described in Section 1 to the individuals who are affiliated with the school/agency indicated in Section III.</p> <p>This authorization expires on: _____</p> <p style="text-align: center;"> _____ Parent Signature Date </p> <p style="text-align: center;"> _____ Student Signature Date </p>		
<p>If the student is a minor authorized to consent to health care without parental consent under federal and state law, only the student shall sign this authorization form.</p>		
SECTION III – AGENCY RECEIVING INFORMATION		
AGENCY/SCHOOL:	<p>This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any agency or person not listed on this form without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.</p> <p>See chapter 70.02 RCW.</p> <p>Envelope shall be marked "CONFIDENTIAL".</p>	
NAME/POSITION (Nurse, Administrator, etc.) _____ _____		
ADDRESS: _____ _____ _____		

Sample LHCP Letter Regarding Unlicensed Staff Administering Emergency Medication at School

Dear: _____

Date: _____

The new Washington State *Guidelines for Care of Students with Anaphylaxis* (2009) includes current best practice information from recognized national authorities regarding anaphylaxis and administering epinephrine (see attached). Based on the attached information, the guidelines provide the following recommendations for Washington schools:

1. If a student, known to have anaphylaxis, has an exposure or a suspected exposure to an allergen, epinephrine is to be given immediately and the EMS (911) system activated.
2. If a LHCP orders the administration of an antihistamine and/or epinephrine, the R.N. may use the [Scope of Practice Decision Tree](#) to follow RCW 18.79, to determine if a non-licensed staff member may carry out the emergency care plan (ECP).
3. Address the unique circumstances for each student while retaining adherence to the scope of nursing practice.

Given the attached information and the above recommendations, the emergency procedure for this student when experiencing possible anaphylaxis will be to:

- 1. Administer Epinephrine**
- 2. Call 911**
- 3. Call Parent/Guardian**

Additional contributing circumstances:

1. In most situations non-licensed school staff (health clerks, secretaries, principals, teachers, coaches, bus drivers, etc.) will be the front line adults on site when the student has a contact to the specific allergen causing potential anaphylaxis.
2. Upon consulting with NCQAC staff, it was determined “waiting and watching” could require a degree of assessment requiring judgment beyond a non-licensed individual.
3. For the safety of the student, epinephrine will be administered immediately as ordered by the health care provider.

Thank you for your assistance in implementing this requirement. Please contact me if you have any questions.

Sincerely,

School Nurse

Phone

The medical standard of care, written by AAAAI states, *“Epinephrine has long been regarded as the treatment of choice for acute anaphylaxis. This is true despite the recognition of its potential hazards. Alternative treatments - such as antihistamines, sublingual isoproterenol, inhaled epinephrine, and corticosteroids without epinephrine - have failed to prevent or relieve severe anaphylactic reactions. It is therefore inappropriate to use them for the first-line treatment or prevention of anaphylaxis.”*

AAAAI Press Room, “Position Statement the Use of Epinephrine in the Treatment of Anaphylaxis.” 2008, http://www.aaaai.org/members/academy_statements/position_statements/ps26.asp accessed on October 30, 2008.

Additionally, in July 2008, the World Allergy Organization published the following statements,

Anaphylaxis is an acute and potentially lethal multisystem allergic reaction. Most consensus guidelines for the past 30 years have held that epinephrine is the drug of choice and the first drug that should be administered in acute anaphylaxis. Some state that properly administered epinephrine has no absolute contraindication in this clinical setting. A committee of anaphylaxis experts assembled by the World Allergy Organization has examined the evidence from the medical literature concerning the appropriate use of epinephrine for anaphylaxis. The committee strongly believes that epinephrine is currently underused and often dosed suboptimally to treat anaphylaxis, is underprescribed for potential future self-administration, that most of the reasons proposed to withhold its clinical use are flawed, and that the therapeutic benefits of epinephrine exceed the risk when given in appropriate intramuscular doses.

Based on available evidence, the benefit of using appropriate doses of intramuscular epinephrine in anaphylaxis far exceeds the risk.... Consensus opinion and anecdotal evidence recommend epinephrine administration sooner rather than later, that is, when the initial signs and symptoms of anaphylaxis occur, regardless of their severity, because fatalities in anaphylaxis usually result from delayed or inadequate administration of epinephrine. Experts may differ on how they define the clinical threshold by which they define and treat anaphylaxis. However, they have no disagreement whatsoever that appropriate doses of intramuscular epinephrine should be administered rapidly once that threshold is reached. There is no absolute contraindication to epinephrine administration in anaphylaxis, and all subsequent therapeutic interventions depend on the initial response to epinephrine.

AAAAI Board of Directors, “Position Statement Anaphylaxis in Schools and Other Child-Care Settings,” 2008, http://www.aaaai.org/media/resources/academy_statements/position_statements/ps34.asp, accessed on February 26, 2008.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

**THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY
(Please clearly print legible instructions)**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time(s) to Be Taken</u>
_____	_____	_____	_____

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication. _____ Yes _____ No

I request and authorize this student to self-administer their medication. _____ Yes _____ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) (**not to exceed current school year**). There exists a valid health reason which may make administration of the medication advisable during school hours.

Date of Signature Licensed Health Professional (LHP)

Telephone Number Name (**please print**)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- ◆ I request this medication to be given as ordered by the licensed health professional.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- ◆ Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ◆ All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

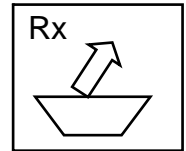
I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No

Date of Signature Parent/Guardian Signature

Telephone Numbers: _____ (home) _____ (work) _____ (cell)

Reviewed by Registered Nurse: _____ Date: _____

**Children with a Life-Threatening Food Allergy
Diet Prescription for Meals at School**



Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____

Major life activity affected: _____

Or

Brief description of medical condition: _____

Diet prescription (check all that apply):

Increased calorie
_____ #kcal

Decreased calorie
_____ #kcal

Diabetic

PKU

Food allergy

Other _____

Texture Modification

chopped

ground

pureed

liquefied

Tube feeding

liquefied meal

formula _____ type _____

Foods to Omit

Foods to Substitute

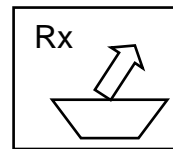
I certify the above-named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Licensed Physician Signature

Date

Phone Number

**Children with Special Dietary Needs
Diet Prescription for Meals at School**



Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____

Nondisabling medical condition: _____

Or

Brief description of medical condition: _____

Diet prescription (check all that apply):

Increased calorie
_____ #kcal

Decreased calorie
_____ #kcal

Diabetic

PKU

Food allergy

Other _____

Texture Modification

chopped

ground

pureed

liquefied

Tube feeding

liquefied meal

formula _____ type _____

Foods to Omit

Foods to Substitute

I certify the above-named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Licensed Physician Signature

Date

Phone Number

LIFE-THREATENING ALLERGY CARE PLAN

Place
student
picture
here

NAME:		Severe ALLERGY to:	
		Other Allergies:	
Please list the specific symptoms the student has experienced in the past:		Asthma? <input type="checkbox"/> Yes (High risk for severe reaction) <input type="checkbox"/> No	
School:	Date of Birth:	Grade:	Routine medications (at home/school):
Bus #	Car <input type="checkbox"/>	Walk <input type="checkbox"/>	Date of last reaction:
Location(s) where EpiPen®/Rescue medications is/are stored:			
<input type="checkbox"/> Office <input type="checkbox"/> Backpack <input type="checkbox"/> On Person <input type="checkbox"/> Coach <input type="checkbox"/> Other _____			

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	“Thready” pulse, “passing out,” fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS

EpiPen® (0.3) <input type="checkbox"/>	EpiPen Jr.® (0.15) <input type="checkbox"/>	Side Effects:
Repeat dose of EpiPen®: <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, when
Antihistamine: _____ cc/mg		Give: _____ Teaspoons _____ Tablets by mouth
Side Effects:		
♦ It is medically necessary for this student to carry an EpiPen® during school hours. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student may self-administer EpiPen®. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student has demonstrated use to LHCP. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Licensed Health Care Provider's Signature:		Date:
Licensed Health Care Provider's Printed Name:		Phone: Fax Number:

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
- ♦ **NOTE TIME** _____ AM/PM (EpiPen®/adrenaline given) ♦ **NOTE TIME** _____ AM/PM (Antihistamine given)
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER EpiPen® is administered.**
- **DO NOT HESITATE to administer EpiPen® and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and EpiPen® is being administered.
- An adult trained in CPR is to stay with student—monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at _____.
- ♦ Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
- ♦ Notify the administrator and parent/guardian.
- ♦ Dispose of used EpiPen® in “sharps” container or give to EMS along with a copy of the Care Plan.

Individual Considerations

Bus –Transportation should be alerted to student’s allergy.

- ◆ This student carries Epipen® on the bus: Yes No
- ◆ Epipen® can be found in: Backpack Waistpack On Person Other (specify) _____
- ◆ Student will sit at front of the bus: Yes No
- ◆ Other (specify): _____

Field Trip Procedures – Epipen® should accompany student during any off campus activities.

- ◆ Student should remain with the teacher or parent/guardian during the entire field trip: Yes No
- ◆ Staff members on trip must be trained regarding Epipen® use and student health care plan (plan must be taken).
- ◆ Other (specify) _____

CLASSROOM –For Food allergy only

- ◆ Student is allowed to eat only the following foods: _____
- Those in manufacturer’s packaging with ingredients listed and determined allergen-safe by the nurse/parent or _____
- Those approved by parent.
- Middle school or high school student will be making his/her own decision.
- Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◆ Student should have someone accompany him/her in the hallways. Yes No
- ◆ Other (specify): _____

CAFETERIA **NO Restrictions**

- Student will sit at a specified allergy table.
- Student will sit at the classroom table cleansed according to procedure guidelines prior to student’s arrival and following student’s departure.
- Student will sit at the classroom table at a specified location.
- ◆ Cafeteria manager and hostess should be alerted to the student’s allergy.
- ◆ Other: _____

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:
4.	Relationship:	Phone:

- ◆ I request this medication to be given as ordered by the licensed health care provider.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- ◆ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ◆ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.
- ◆ I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No
- ◆ This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature	Date
Student demonstrated to the nurse the skill necessary to use the medication and any device necessary to self-administer the medication. Device(s) if any, used: _____ Expiration date(s): _____	
School Nurse Signature	Date

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.

Sample Training Program

Teaching Plan Objectives

The learner will:

1. Identify (name) _____'s allergies.
2. Identify the signs and symptoms of an allergic reaction and anaphylaxis.
3. Be able to initiate treatment for an allergic reaction and specifically carry out an emergency allergy treatment plan.
4. Demonstrate how to use the EpiPen® or EpiPen® Jr. effectively as a treatment for an allergic reaction and anaphylaxis.
5. Understand the potential for cross-contamination of identified allergens.
6. Be able to communicate to students, caregivers, and other staff information about allergies and precautions.
7. Understand how Section 504 applies to students with allergies.

Methods of Delivery and Time Frame

The learner will complete the pre-assessment prior to the initial training session. At the initial training session, (student's name)'s and allergies will be identified, allergy kit supplies identified and explained, emergency allergy treatment plan discussed, and use of EpiPen® Jr. demonstrated. The learner will demonstrate knowledge of (student's name)'s and allergies, knowledge of location of allergy supplies, and proper use of EpiPen® Jr. Any questions will also be answered. The Allergy Training Kit will be given to the learner and a follow-up training session will be scheduled.

Estimated time of initial training session: 20 minutes.

At the follow-up training session, the learner will demonstrate knowledge of (student's name)'s and allergies, knowledge of location of allergy supplies, and proper use of EpiPen® Jr. In addition, the learner will demonstrate knowledge of anaphylaxis, cross-contamination, and Section 504 as it applies to the student with allergies. Knowledge will be demonstrated through use of EpiPen Jr.® Trainer, discussion, and completion of both the training assessment and post-assessment. Estimated time frame: 20–30 minutes.

Instructional Media

The Allergy Training Kit is contained in a briefcase-like plastic case with a handle. It contains the following instructional media:

EpiPen® Jr. Trainer

This is a duplicate of the actual EpiPen® Jr. used to treat allergic reactions and anaphylaxis. It does not contain a needle or epinephrine, and can be reset and used repeatedly for instruction and demonstration.

Videos

1. It Only Takes One Bite: Food Allergy and Anaphylaxis Video
2. Alexander, The Elephant Who Couldn't Eat Peanuts Video

Books

1. Getting Started with Food Allergies: A Guide for Parents
2. Just One Little Bite Can Hurt! Important Facts About Anaphylaxis
3. Off to School with Food Allergies, Parent/Teacher Set
4. Students with Food Allergies: What Do the Laws Say?
5. Nutrition Guide to Food Allergies
6. A Special Day at School
7. Andrew and Maya Learn About Food Allergies
8. Food Allergy Network Ordering Brochure
9. Miss Roben's Catalog

Printed References

This is a collection of physician's orders, articles, resources, and Web sites from various sources including newspapers, magazines, and the World Wide Web. The Emergency Allergy Treatment Plan individual health plan/emergency health plan (IHP/ECP) is written by the student's LHCP and updated yearly. It is the actual treatment orders to be given to personnel such as emergency medical technicians or emergency room staff. A copy of the IHP/ECP is also kept with the medical kit, which contains the EpiPen® Jr. and Benadryl®.

Pre-Assessment for Allergy and Anaphylaxis Training

Please rate the following statements using the number scale from 1 to 5

1 = strongly agree 2 = somewhat agree 3 = neither agree nor disagree

4 = somewhat disagree 5 = strongly disagree

I know the signs and symptoms of an allergic reaction.

1 2 3 4 5

I know how to initiate treatment for an allergic reaction and anaphylaxis.

1 2 3 4 5

I know how to use an epinephrine auto-injector.

1 2 3 4 5

I am confident in using an epinephrine auto-injector.

1 2 3 4 5

I know about cross-contamination and allergens.

1 2 3 4 5

I know how Section 504 pertains to students with allergies.

1 2 3 4 5

I am confident being responsible for the well-being of student with allergies.

1 2 3 4 5

Sample Allergy and Anaphylaxis Training Assessment
(Red font indicates correct answers)

1. What is anaphylaxis?
 - An allergic reaction
 - A sudden, life-threatening allergic reaction
 - An asthma attack
2. Signs and symptoms of an allergic reaction include (check all that apply):
 - Itchy, red rash
 - Hives
 - Sneezing
 - Itching, swelling, or hoarseness of the throat
 - Shortness of breath, cough, and/or wheezing
 - Weak pulse or loss of consciousness (“passing out”)
 - Hyperactivity
 - Abdominal pain/discomfort
3. Signs and symptoms of anaphylaxis include (check 1 of the following):
 - Extreme agitation, restlessness
 - Itching and swelling of the lips or tongue, hives, difficulty breathing, vomiting
 - Lethargy, drowsiness
4. If a child with a food allergy complains of any of the above symptoms, it is best to wait and be sure rather than provide emergency treatment. True **False**
5. A food allergy reaction or anaphylaxis only occurs after the food-allergic person eats a large amount of the allergy food. True **False**
6. If not treated immediately, a food allergy reaction can cause death. **True** False
7. Epinephrine does not need to be given for a bee sting unless the student complains of difficulty breathing, even if the nursing care plan documents a history of anaphylaxis.

True **False**

8. Which of the following are possible side effects of epinephrine?
- Elevated blood pressure, itching
 - Headache, nausea
 - Heart palpitations, anxiousness, headache
 - Drowsiness, lethargy
9. If the allergy symptoms are relieved after giving epinephrine, Emergency Medical Services (911) do not need to be called. True False
10. If a food doesn't have a label, it is better not to give it to a student with food allergies even if he/she says they think they have had it before. True False
11. Everyone experiencing a life-threatening allergic reaction will have hives. True False
12. I have demonstrated I am able to use the epinephrine auto-injector. Yes No
13. The epinephrine auto-injector should be given only if an allergy reaction is severe, otherwise treatment should begin with an antihistamine while waiting for emergency personnel or doctor's advice. True False
14. Stops the symptoms of the allergic reaction.
(circle one) Epinephrine Antihistamine
15. Lessens the effect of the allergic reaction.
(circle one) Epinephrine Antihistamine
16. When using the epinephrine auto-injector, it must be held in place for 10 seconds for all the medication to be released.
17. A child with a latex allergy can experience a latex allergen exposure from _____. Balls, gym equipment, balloons, and first aid gloves.
18. A child eats a sandwich containing peanut butter and a classmate has a peanut allergy, cross-contamination can be reduced by (check 1 of the following):
- Thoroughly washing hands with soap and water after eating and thoroughly washing the eating surface with soap and water.
 - Using a paper towel to clean up any peanut butter that falls out of the sandwich
19. Craft activities that use foods known to cause allergic reactions in students are safe to do because they won't be eaten. True False
20. Schools are not considered a high risk setting for exposure to allergens and cross-contamination for students with life-threatening allergies. True False

21. Life-threatening allergy is classified as a disability under Section 504. True False

22. The classroom is the most common area students in school are reported to experience an allergic reaction.

True False

23. In order to implement a child's emergency care plan a staff person needs to know

(check one of the following):

- The name of the allergen, where the emergency care plan is kept, and how to administer the epinephrine auto-injector.
- The students name, how to activate emergency medical services (911), and cardio-pulmonary resuscitation (CPR).
- The symptoms of anaphylaxis, how to give the epinephrine auto-injector and other necessary medication, and how to activate emergency medical services (911).
- The name of the allergen, the symptoms of anaphylaxis, and where the epinephrine auto-injector is stored.

24. A child complains of continued asthma symptoms even after using a rescue medication inhaler. You know this student has a life-threatening allergy to peanuts and it has been 30 minutes since the student finished eating lunch. You suspect this student may have been exposed to peanut butter at lunch.

Describe the next steps you would take.

Evaluation for Allergy and Anaphylaxis Training

Please rate the following statements using the number scale from 1 to 5

1 = strongly agree 2 = somewhat agree 3 = neither agree nor disagree

4 = somewhat disagree 5 = strongly disagree

I know how to use an epinephrine auto-injector and am confident in using it.

1 2 3 4 5

I am confident being responsible for the well-being of a student with allergies.

1 2 3 4 5

I understand and feel confident in following the Emergency Care Plan for a student with anaphylaxis.

1 2 3 4 5

I found the training session(s) to be very effective.

1 2 3 4 5

The training time was adequate.

1 2 3 4 5

Comments:

It was helpful to have the Allergy Training Kit on my own for study.

1 2 3 4 5

The videos were helpful.

1 2 3 4 5





Comments:

The booklets by the Food Allergy Network and the additional resources were helpful.

1 2 3 4 5

Comments:

EpiPen® Training for School Staff

	EpiPen® Injection Procedure:	Date Step Discussed	Date Skill Demonstrated
	<p>1. Remove the container device from its protective container.</p> 		
	<p>2. Pull off gray safety cap from the fatter end of the device (this "arms" the unit ready for use).</p> 		
	<p>3. Place black tip on outer thigh. Injection into the skin is best, but it can be injected through clothing. <i>Hold</i> the EpiPen® in your fist with clenched fingers wrapped around it.</p> 		
	<p>4. Push EpiPen® auto-injector against thigh until unit activates (until a loud "click" is heard) and then hold in place 10 seconds.</p>		
	<p>5. Remove the pen from the thigh; avoid touching the needle that will now be projecting from the EpiPen® when you dispose of the device.</p> 		
	<p>7. Massage the injection site to increase epinephrine absorption. There may be some slight bleeding at the injection site. (Apply firm pressure with a cloth, tissue, clean handkerchief, or bandage.)</p>		
	<p>8. Carefully place the used auto-injector (without bending the needle), needle-end first, into the storage tube of the carrying case that provides built-in needle protection after use, then screw the cap of the storage tube back on completely and send with student to ER.</p>		
	<p>9. Call 911 and stay with the student until EMS arrives:</p> <ul style="list-style-type: none"> • Record the time the EpiPen® was given on the Emergency Care Plan and give EMS a thorough report. • Give EMS the used EpiPen® and the Emergency Care Plan. 		

Staff Member Trained: _____

Date: _____

School Nurse Trainer: _____

Date: _____

Adapted with permission from ESD 114 SNC Program

Sample School Staff Emergency EpiPen® Medication Administration Checklist

Name of student for whom training is needed: _____

Skills List	Demonstration Date	Review Date	Rev Date	Rev Date
Review signs and symptoms of life-threatening allergic reaction/anaphylaxis (See Emergency Care Plan).				
Locate student's Emergency Care Plan (ECP).				
Locate student's EpiPen® (as noted on ECP).				
Review criteria on ECP for giving EpiPen®.				
If administration of EpiPen® is indicated, direct another adult to implement school Emergency Procedures* or send two students to office for assistance at site. (*Review district/school plan).				
Perform Five "Rights:" 1. Right person —ask student's full name and compare with EpiPen® label. 2. Right drug —check EpiPen® label for correct student. 3. Right amount —check both ECP directions and EpiPen® label. 4. Right time —review criteria in ECP. 5. Right method of administration—follow procedure in ECP.				
Perform EpiPen® injection procedure: 1. Pull off <u>gray safety cap</u> . 2. Place <u>black tip</u> on upper outer thigh. 3. Using a quick motion press hard into upper outer thigh. 4. Hold in place and count to 10. 5. Remove EpiPen® and hold safely away from student and staff. 6. Massage the injection area for 10 seconds. 7. Carefully place the used auto-injector (without bending the needle), needle-end first, into the storage tube of the carrying case that provides built-in needle protection after use, then screw the cap of the storage tube back on completely and send with student to ER.				
Reassure and calm student.				
Record time EpiPen® was given on ECP, initial, and send a copy of ECP with ambulance.				
Continue to observe student for breathing difficulties or further deterioration of consciousness and breathing.				
Administer CPR if no signs of life, i.e., no breathing, gagging, coughing, or chest movement.				
Reviewed self-advocacy.				

I voluntarily received this training for anaphylaxis and EpiPen® use. In the event there are no licensed personnel to administer this life saving medication in an emergency, I will follow the above protocol.

School Staff Signature: _____ **Date:** _____

The above faculty/staff has received the above training and demonstrates sufficient knowledge to act in an emergency.

R.N. Signature: _____ **Date:** _____

Adapted with permission from ESD 171 SNC Program

Sample Registered Nurse Checklist for Students with Life-Threatening Food Allergies

Student: _____ **Allergen:** _____ **School:** _____
Birthdate: _____ **Grade/Teacher:** _____
Allergist or LHCP Name and Phone Number: _____
Age of onset: _____ **Brief history:** _____
Date(s) of hospitalization(s)/ER visits: _____
Concurrent illness or disability or related social/emotional factors: _____

Purpose: To provide a safe environment, promote student food allergy self-management, recognize signs of anaphylaxis, and provide appropriate assistance and emergency care.

Activities to be reviewed:

1. **Field trips** – All treatment supplies are taken and care is provided:
 By accompanying parent.
 By school staff trained in student’s emergency care plan (ECP).
2. **In the event of classroom/school parties, food treats will be handled as follows:**
 Student will eat treat if ingredients listed are approved by parent.
 Parent supplies all snacks and treats for student stored in a marked container kept by the teacher.
3. **After-school activities:** _____
4. **Special eating arrangements:** _____

Activities student can self-manage:

1. **Student responsibility:**
 Will not trade food with others.
 Will not eat anything with unknown ingredients or known allergen.
 Will notify an adult immediately if eats something they believe may contain food allergen.
 Will wear a medic alert bracelet or dog tag necklace.
 Yes No: Wants the Protect a Life (PAL) or similar education program for schoolmates.
 Yes No: Will self-carry EpiPen® with medical authorization form; location: _____
2. **Epinephrine injections:**
 Yes No: Administers independently (trained/authorized by LHCP and reviewed by school nurse), if able to do so.
 Trained school staff should be available to supervise and observe.
 Yes No: Administration by nurse or trained staff. Location of medication: _____

Teacher Responsibilities:

- Know the ECP and classroom accommodations.
- Know the location of all emergency information and medications.
- Be trained to administer EpiPen®.
- Inform substitutes of ECP.
- Set up a plan for student to inform you if they are having a reaction.
- Help educate classroom about allergies.
- Be prepared for special events, parties, field trips (contact parent prior to events).
- Instruct students not to share food and eating utensils.
- Read contents of teaching materials such as science kits to identify potential allergens.

Parent Responsibilities:

- Provide EpiPen® and/or other prescribed medications with the Medication Authorization Form signed by the LHCP on or before the first day of school.
- Inform nurse of any changes or allergic/anaphylactic episodes.
- Obtain a medic alert bracelet or dog tag style necklace for the student.
- Provide lunch from home (safest option).
- Complete diet order form information for school prepared meals.
- School menus will be previewed by parent and student to self select foods from school menu (be aware menu items change).

Nurse/School Responsibilities:

- Complete ECP and attach to IHP.
- Notify school nutrition services director and cook at school.
- Review eating arrangements if needed, e.g., peanut -safe table, desk wipe down.
- Verify school bus driver received ECP and training.
- Train school staff (awareness of allergens, allergic symptoms and ECP, conduct mock drill).
- Train school staff in location and administration of emergency medications/Epipen®.

Parent Date

School Nurse Date

Teacher Date

Student Date

Adapted with permission from Northshore School District

Sample Sack Lunch Request Form



Date of Request: _____

(Minimum One Week Notice Required)

School: _____

Teacher: _____ Grade/Room: _____

Date of Field Trip: _____ Requested Delivery Date to Kitchen: _____

Number of Lunches Requested: _____

Time for Sack Lunch Pick-Up in Cafeteria: _____

*** Are there student(s) with food allergies/special dietary needs? Yes _____ No _____**

List children with food allergies/special dietary needs (appropriate documentation must be on file with lunchroom manager):

First Name	Last Name	Specific Food Allergy <u>OR</u> Special Dietary Need

ATTN. TEACHERS: If someone other than the student(s) is picking up the sack lunches, the teacher requesting the lunches must provide a roster of the names and pin number or ID#'s of all students for whom sack lunches are being requested. Attach additional sheets if required. The student roster should be used as the official check off form for sack lunches when they are distributed at the field trip site. Form cannot be completed (acknowledging receipt of meals) prior to meal distribution.

Completed Forms must be returned to the lunchroom staff after the event has occurred!

For Nutrition Services Use Only:	
Date Received: _____	Number of Lunches: Regular: _____
Date Ordered: _____	Vegetarian: _____
	Other (see above): _____

Adapted with permission from Seattle School District

Sample Substitute Teacher Letter

Dear Substitute Teacher,

Students in Room _____ have life-threatening food allergies or other conditions. Their names are listed below.

If you have not been trained on recognizing anaphylaxis and administering epinephrine for students listed, please see the school nurse or an administrator before taking responsibility for this classroom.

- Familiarize yourself with the care plans (attached) and make sure you are able to identify each of these children in the classroom.
- Locate and identify any medicine stored in the room. Please follow all risk reduction protocols established for the room.
- Do not offer food to the class or to any food allergic student without prior approval of the teacher, nurse, or parent.

If a student experiences an anaphylactic reaction while in your care, quick administration of epinephrine by an auto-injector is critical.

<u>Student</u>	<u>Allergies</u>	<u>Other Conditions</u>	<u>EpiPen® stored in room?</u>	
_____	_____	_____	<u>YES</u>	<u>NO</u>
_____	_____	_____	<u>YES</u>	<u>NO</u>
_____	_____	_____	<u>YES</u>	<u>NO</u>
_____	_____	_____	<u>YES</u>	<u>NO</u>

Your cooperation in implementing these health plans is vital to our students' safety.

If you have questions, contact the school nurse or the principal.

Classroom Teacher

Adapted with permission from Kelly Morgan (parent)

Sample Classroom Letter

Please note you must gain written parental consent to share information with other parents first!

Dear Parent:

Date:

This letter is to inform you a student in your child's classroom has a life-threatening food allergy to _____ . Strict avoidance (not being around the food) is the only way to prevent a life-threatening allergic reaction. We ask for your assistance in keeping this student safe.

If exposed to _____, by eating or through touching, the student may develop a life-threatening allergic reaction that may result in death. To reduce the risk and maintain safety for this child, the classroom will have an allergen-safe zone. *Please do not send any products containing _____ with your child to eat in the classroom.* Many foods you would not think contain _____ actually do. The best way to determine whether or not the food contains _____ is to carefully read the ingredient labels to see if _____ is a listed ingredient and the allergy alerts located on the product packaging. For example, the allergy alerts may read:

- . . . may contain traces of _____.
- . . . produced on machinery that also processes _____.
- . . . produced in a facility that processes _____.

While we know this is an extra step, your help is needed, due to the seriousness of the consequences.

Any exposure to _____ may cause a severe allergic reaction. If your child has eaten _____ before school, please be sure your child's hands and face have been thoroughly washed with warm water and soap prior to coming to school. Soap and water is the best way to remove food residue from hands.

During meals there is an allergen-safe or PALS table where any classmate without _____ products can sit. If your child sits at this table with a _____ product, he/she will be asked to move to another table to reduce the spread of allergens around the room. This plan will help maintain safety in the classroom while allowing non-allergic classmates to enjoy _____ products. Following lunch, the children will be required to wash their hands with warm water and soap to reduce the risk of contamination by touching playground and classroom surfaces.

Please complete and return this form so we know every family has received this information. If you have any questions, please contact us at _____.

Sincerely,

Principal

Teacher

I have read and understand this letter. I agree to do my part in keeping the classroom and school safer for all students.

Child's Name: _____ Parent's Signature: _____ Date: _____

Adapted with permission from Massachusetts *Anaphylaxis Guidelines*

Sample School Letter to All Parents

Dear Parents:

Date: _____

This letter is to inform you that there are several students at our school (insert name) who have life-threatening food allergies. These students are allergic to the following foods:

Eating these foods, even in trace amounts, may cause a severe reaction (anaphylaxis) that can lead to death. The following symptoms may occur: hives, difficulty breathing, vomiting and diarrhea, swelling of the lips, mouth, and throat, itching and sneezing, loss of consciousness, and death due to shock. Even touching contaminated surfaces may cause a reaction. School staff have been trained to recognize such a reaction and to administer medication (epinephrine) in an emergency.

You can help staff and the school by taking advantage of opportunities to learn more about food allergies and by helping your child understand the foods they freely enjoy can be dangerous to others. Equally important, however, is to let them know they can support their classmates by eating and handling food responsibly.

Here are a few suggestions for you as parents:

- Never take food allergies lightly; they can be serious and life-threatening.
- Ask your child's friends what they are allergic to and help them avoid it.
- **Tell your child, "do not share food."**
- Frequent hand washing reduces the spread of viruses during the school year and helps protect food allergic students. Wash hands thoroughly after eating. Similarly, encourage good hygiene before and after-school. Ask your child to wash up if they have been particularly messy during breakfast. Wash hands and surfaces before handling library or text books or school equipment.
- Tell your child to get help from an adult immediately if a schoolmate has a reaction.

This school may have a Be a PAL Zone in the lunchroom/classroom. This is a designated area where students eat meals that do not contain specific food items or products such as peanuts and peanut butter. Additionally, an area may be designated in the lunchroom/classroom where students may only eat certain foods such as a peanut product table.

If you have questions or concerns, please contact the school nurse or the principal. Thank you very much for your understanding and cooperation.

Adapted with permission from Kelly Morgan (parent)

WSSDA Sample Policy

ANAPHYLAXIS PREVENTION

The _____ board of directors expects school administrators, teachers and support staff to be informed and aware of life-threatening allergic reactions (anaphylaxis) and how to deal with the resulting medical emergencies. For students, some common life-threatening allergens are peanuts, tree nuts, fish, bee or other insect stings, latex, and some medications. Affected students require planned care and support during the school day and during school-sponsored activities.

Parents/guardians are responsible for informing the school about their student's potential risk for anaphylaxis and for ensuring the provision of ongoing health information and necessary medical supplies. The district will take reasonable measures to avoid allergens for affected students. The district will also train all staff in the awareness of anaphylaxis and prepare them to respond to emergencies. Additionally, student specific training will be provided for appropriate personnel.

Even with the district's best efforts, staff and parents/guardians need to be aware that it is not possible to achieve a completely allergen-free environment. However, the district will take precautions to reduce the risk of a student having an anaphylactic reaction by developing strategies to minimize the presence of allergens in schools.

The superintendent will establish procedures to support this policy.

Management Resources:

Policy News, February 2009 Anaphylaxis Prevention Policy Required

Document provided with permission by WSSDA

WSSDA Sample Procedure

ANAPHYLAXIS PREVENTION

For students with a medically diagnosed life-threatening allergy, the district will take appropriate steps for the student's safety, including implementing a nursing care plan.

Parent/Guardian Responsibility

Prior to enrolling a student, the parent/guardian will inform the school in writing of the medically diagnosed allergy(ies) and risk of anaphylaxis. Upon receiving the diagnosis, school staff will contact the parent/guardian to develop a nursing care plan. A nursing care plan will be developed for each student with a medically diagnosed life-threatening allergy.

Nursing Care Plan

The written plan will identify the student's allergies, symptoms of exposure, practical strategies to minimize the risks, and how to respond in an emergency.

The principal or designee (school nurse) may arrange a meeting (*or telephone call*) with the parent/guardian prior to the first day of attendance to develop and discuss the nursing care plan. The plan will be developed by the parent, school nurse, and appropriate school staff. If the treatment plan includes self-administration of medications, the parents, students, and staff will comply with model policy and procedure 3419, *Self-Administration of Asthma and Anaphylaxis Medication*.

Annually and prior to the first day of attendance, the student health file will contain: (1) a completed nursing care plan; (2) a written description of the treatment order, signed by a licensed health care provider; and (3) an adequate and current supply of auto-injectors (or other medications). The school will also recommend to the parents that a medical alert bracelet be worn by the student at all times. The parents/guardians are responsible for notifying the school if the student's condition changes and for providing the medical treatment order, the auto-injectors, and medications.

Students who have a medically diagnosed life-threatening allergy and no medication or treatment order presented to the school, shall be excluded from school to the extent that the district can do so consistent with federal requirements for students with disabilities under the Individuals with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, and pursuant to the following due process requirements:

- A. Written notice to the parents, guardians, or persons in loco parentis is delivered in person or by certified mail.
- B. Notice of the applicable laws, including a copy of the laws and rules.
- C. The order that the student shall be excluded from school immediately and until medications or a treatment order is presented.

Communications Plan and Responsibility of School Staff

After the nursing care plan is developed, the school principal or a designee will inform appropriate staff regarding the affected student. The school nurse (R.N.) will train appropriate staff regarding the affected student and the nursing care plan. The plan will be distributed to appropriate staff and placed in appropriate locations in the district (classroom, office, school bus, lunchroom, etc.). With the permission of parents/guardian and the student, (if appropriate), other students and parents may be given information about the student's condition

In-service Training

Annually, each school principal will provide an in-service training on how to minimize exposure and how to respond to an anaphylaxis emergency. The training will include a review of avoidance strategies, recognition of symptoms, the emergency protocols to deal with an anaphylaxis episode, and use of an auto injector.

Student specific training and additional information will be provided (by the school nurse) to teachers, teacher's assistants, clerical staff, food service workers, and bus drivers who will have known contact with a diagnosed student.

Controlling the Exposure to Allergens

Controlling the exposure to allergens requires the cooperation of parents, students, the health care community, school employees, and the board. The district will inform parents of the presence of a student with life-threatening allergies in their child's classroom and/or school and the measures being taken to protect the affected student. Parents will be asked to cooperate and avoid including the allergen in school lunches and snacks or other products. The district will discourage the sharing of food, utensils, and containers. The district will take other precautions such as avoiding the use of party balloons or contact with latex gloves. Additionally, play areas will be specified that are lowest risk for the affected student.

The district will also identify high-risk events and areas for students with life-threatening allergies, such as foods and beverages brought to school for seasonal events, school equipment, and curricular materials used by large numbers of students (play-dough, stuffed toys, science projects, etc.)

During school-sponsored activities, appropriate supervisors, staff, and parents will be made aware of the identity of the student with life-threatening allergies, the allergens, symptoms, and treatment. The lead teacher will ensure that the auto-injector is brought on field trips.

Date: 02.09

Document provided with permission by WSSDA

SECTION 6

RESOURCES

(Recommended by the Food Allergy Workgroup members)

OSPI does not necessarily endorse or support the information expressed in the following resources listed below:

Accommodating Children with Special Dietary Needs (USDA)
http://www.fns.usda.gov/cnd/Guidance/special_dietary_needs.pdf

Allergy and Asthma Foundation of America <http://www.aafa.org/>

American Academy of Allergy, Asthma and Immunology <http://www.aaaai.org/>

American Academy of Pediatrics <http://www.aap.org/>

American Dietetic Association
<http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/index.html>

American Latex Allergy Association <http://www.latexallergyresources.org/>

Center for Chronic Disease Prevention and Health Promotion: DASH Healthy Youth Food Allergies <http://www.cdc.gov/HealthyYouth/foodallergies/>

Department of Health Food Safety Program
<http://www.doh.wa.gov/ehp/sf/food/food.htm>

Food Allergy and Anaphylaxis Network <http://www.foodallergy.org/>

Food Allergy Initiative
http://www.foodallergyinitiative.org/section_home.cfm?section_id=7

National Association of School Nurses <http://www.nasn.org/>

New York Food Allergy Training Module for Nurses
http://schoolhealthservices.org/tool_kit.cfm?subpage=97

OSPI Child Nutrition Services Food Allergy Kits – Please contact ESD School Nurse Corps Administrators at <http://www.k12.wa.us/HealthServices/ESDcontacts.aspx> or OSPI Child Nutrition Services at (360)725-6200

Revolution Health Allergy Guides www.revolutionhealth.com

Safe@School Partners <http://www.foodallergysmart.org/index.htm>

Seattle FEAST (Food Education and Allergy Support Team) www.seattlefoodallergy.org