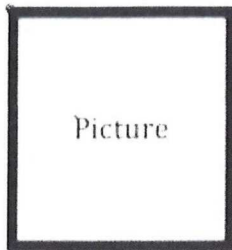


Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956



Food Allergy and Anaphylaxis Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ Parent/Guardian _____

City _____ Zip Code _____ Home Phone _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Allergy to: _____ Weight: _____ lbs.

Is Allergy (check all that apply): Contact Airborne Ingestion

Should your child sit at a designated nut free lunch table? Yes No

Asthma: Yes (higher risk for severe reaction) No

Complete if your child is EXTREMELY REACTIVE:

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**

For any **SEVERE SYMPTOMS** after suspected or known ingestion:
(one or more of the following)

- Lung: Short of breath, wheezing, repetitive cough
- Heart: Pale, blue, faint, weak pulse, dizzy
- Throat: Tight, hoarse, trouble breathing/swallowing
- Mouth: Significant swelling of the tongue and/or lips
- Skin: Many hives over body, widespread redness
- Gut: Repetitive vomiting, severe diarrhea
- Other: Feeling something bad is about to happen, anxiety, confusion



1. **Inject Epinephrine immediately**
2. **Call 911**
3. Consider giving additional medications:
 - a. Antihistamine
 - b. Inhaler (if wheezing)
4. Lay person flat with legs elevated.
5. If symptoms don't improve or worsen after 5 minutes, give second dose of epinephrine if available.
6. Alert emergency contacts.

For any **MILD** symptoms from a **SINGLE SYSTEM**:

Nose: Itchy/runny nose, sneezing
Mouth: Itchy mouth
Skin: A few hives, mild itch
Gut: Mild nausea/discomfort



1. Antihistamine may be given, if ordered by a provider.
2. Stay with person and monitor for changes.
3. If symptoms worsen, give epinephrine if ordered. If given, call 911.
4. Alert emergency contacts.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

My child has a mild reaction and if my child would ingest _____ please call parent. **Medication will not be provided for the school at this time. I understand that if the reaction appears life threatening 911 will be called first.**

Medications/Doses to be given at school:

Epinephrine Brand (Rx label attached): _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM Expiration Date: _____

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____ Expiration Date: _____

Other: (e.g., Inhaler-bronchodilator if wheezing): _____ Exp Date: _____

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____

Wisconsin Department of Public Instruction
MEAL MODIFICATIONS IN THE USDA CHILD NUTRITION PROGRAMS
PI-6314 (Rev 06-24)

U.S. Department of Agriculture (USDA) regulations 7 CFR Part 15b requires school meal modifications be made for children with dietary disabilities when requests are supported by a written statement from a state authorized medical authority or registered dietitian.

A. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act (ADAAA) of 2008, “a person with a disability” means any person who has a physical or mental impairment which substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

These Acts can be found in their entirety at <https://www.eeoc.gov/statutes/rehabilitation-act-1973> and <http://www.eeoc.gov/laws/statutes/adaaa.cfm>.

B. Individualized Education Program

The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. The IDEA can be found in its entirety at <https://sites.ed.gov/idea/statuteregulations>.

When a child’s IEP or 504 plan contains the same information that is required on a medical statement, then it is not necessary to get a separate medical statement from a state authorized medical authority or registered dietitian.

C. Authorized Medical Statement

An authorized medical statement must:

- Include an explanation of how the child’s physical or mental impairment restricts the child’s diet
- Identify the food(s) to be avoided
- Identify the food(s) to be substituted
- Be signed by a state authorized medical authority or a registered dietitian.

Per USDA memo SP 32-2015, a state authorized medical authority is a state licensed health care provider who is authorized to write medical prescriptions under state law. In Wisconsin this is a physician, dentist, optometrist, podiatrist, physician assistant, or nurse practitioner. In addition, the Final Rule-Child Nutrition Programs: Meal Patterns Consistent With the 2020-2025 DGAs, section 14 permits registered dietitians to request meal modifications on behalf of a child with a dietary disability.

If the request for a meal modification is not for a disability or has not been signed by one of these practitioners, the school is not required to provide a meal accommodation.



	I. GENERAL INFORMATION	
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Student's Name	Age	Name of School	Student's PIN / ID Number	Grade
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	II. ACCOMODATIONS	
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1. How does the child's physical or mental impairment restrict his or her diet?

2. What foods or types of food should be omitted? Please be specific.

3. List foods to be substituted (avoid specific brand names unless medically necessary).

4. Additional comments:

	III. SIGNATURES	
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Parent or Legal Guardian's Name	Relationship	Phone Number
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Signature of Parent or Legal Guardian ➤	Date Signed
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Authorized Medical Authority's Name	Title	Dentist	Physician	Phone Number
		Optometrist	Physician Assistant	
		Podiatrist	Registered Dietitian	
		Nurse Practitioner		

Signature of Authorized Medical Authority ➤	Date Signed
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Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
Program.Intake@usda.gov

This institution is an equal opportunity provider.