HEALTHCARE PROVIDER STATEMENT FOR FOOD SUBSTITUTION

This form must be completed if a parent/student is requesting menu substitutions be made in the dining center for a student's food allergy or intolerance

CHILD'S NAME:	DATE:

Dear Parent/Guardian:

Your child's school participates in a federally-funded School-Based Child Nutrition Program that requires CPS to offer meals and/or milk to students. However, when a disability (for example, a food allergy) or special dietary need or restriction documented by a healthcare provider exists, reasonable menu accommodations must be made. Please provide your contact information and ask your child's healthcare provider to complete this form. **Please return the completed form to your child's School Nurse along with a Food Allergy Action Plan** (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

School Name

Parent/Guardian Name

Address (Street)

Parent/Guardian Phone Number

Address (City, State, Zip Code)

*Healthcare providers' note: **Food allergies** are a "disability" under the Americans with Disabilities Act. If the child has a food allergy, please check "Yes" for question 1 below.*

PHYSICIAN STATEMENT

1. Does child have a disability that requires food accommodation?
   - ☐ No If **no**, go to item 2 below.
   - ☐ Yes If **yes**, provide the follow information and complete items 3, 4, and 5

   a) What is the disability? _____

   b) What major life activity is affected? _____

   c) What does the disability mean for the child's diet? _____

2. Child has no disability, but requires a special diet. Identify the medical problem that warrants the child's special diet and complete item 3, 4, & 5 below.

3. List **specific** foods to be omitted:

4. List **specific** acceptable food substitutions. Please attach a menu if applicable:

5. _____ _____
   Signature of Health Care Provider **Date**

Parent/Guardian: Return this form to your School Nurse

FOR SCHOOL USE ONLY: Please scan and email this form to food@cps.edu.

School Nurse Signature: _____

Date reviewed: _____

Date scanned to food@cps.edu: _____

PLEASE GIVE A COPY TO THE SCHOOL NURSE AND LUNCHROOM MANAGER

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: **[ ] Yes (higher risk for a severe reaction) [ ] No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

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** OF THE FOLLOWING:

SEVERE SYMPTOMS

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

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

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

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

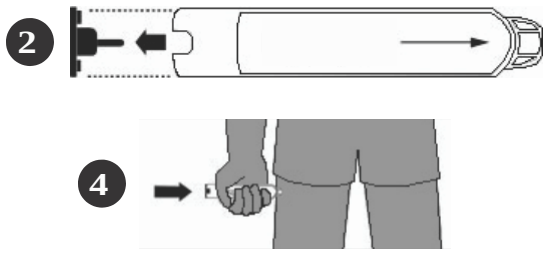
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

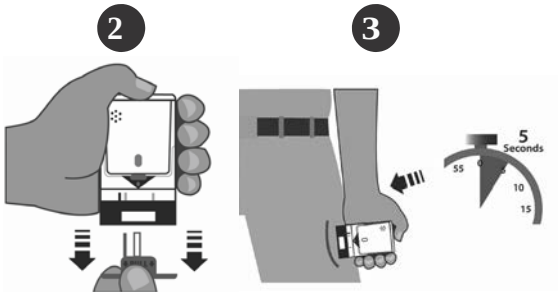
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat someone before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone	Zip Code

I _____ (Mother, Father, Legal Guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's physician _____ during school hours.

NAME OF PHYSICIAN

I will bring the medication to school nurse or principal/designee in original container appropriately labeled by the pharmacist or licensed provider.

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Business Phone

_____
Date

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

Rev 1/19

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
Dosage	Route	Time to be given

_____
Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____**Date** _____

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

Rev. 1/19