Student Name: _____

Teacher: _____

Attachment Policy 209.1

Life Threatening Food Allergy Procedures and Accommodations
Neshannock Township School District

Standard Procedures for all life threatening food allergies:

1. Your child's teacher will be informed of his or her allergy via written notification.
2. The homeroom teacher and other applicable staff will review the information provided in this document and the emergency action plan.
3. The school nurse provides annual training for staff. The educational allergy packet is distributed on the first day of school to faculty, including information on the Epi-Pen.
4. All cafeteria monitors are given a list of all students with life threatening food allergies.
5. We have developed an emergency response protocol that provides instructions on handling a medical emergency and lists the signs of an allergic reaction. Staff members receive a copy of this protocol in the allergy packet.
6. All busses are equipped with communication devices.
7. There is a "no eating" rule for all daily school bus routes.
8. Your child's picture and allergies will show up in the computer system when he or she pays for lunch.
9. Your child will not be permitted to be a lunch bin carrier.
10. Every effort is made to avoid cross contamination issues in food preparation. If there are any questions regarding breakfast or lunch, we recommend you call our food service director for information on the safety of school lunches. (724) 652-8709 ext. 5133. The food service director advises school staff that the nut-free table must be cleaned with a separate cloth and bucket or a disposable cleaning cloth.
11. Teachers must indicate which students have allergies on their substitute information and make action plans available and visible.
12. Classroom activities/crafts/lessons will not involve allergens. If a classroom activity involves food, the teacher will contact the parent in advance so that accommodations may be made to insure safety.

Nut Allergy Procedures:

13. Designated classrooms will be nut-free.
14. A nut-free table will be available in the cafeteria.
15. A confidential allergy notification letter will be sent home with the class explaining the need for a nut-free classroom.
16. If the teacher permits edible treats, they are agreeing to review the ingredient lists and allergen statements of items prior to permitting them in the classroom. Items with any nut ingredient or with statements that might include the risk of cross contamination will NOT be permitted in the classroom. This includes statements such as "processed in a plant that processes nuts, items may come in contact with nut contaminants, etc". Homemade items are not permitted nor are items that do not include an ingredient label.
17. The teacher will direct students to wash their hands with soap and water after lunch (prior to entering the nut-free classroom).
18. A sign designating your child's classroom as "nut- free" will be posted at the entrance. This is a visible reminder to anyone entering the room that nut products are not permitted. All classrooms in grades four through six as well as applicable high school classrooms are nut-free due to block scheduling.

Student Name: _____

Teacher: _____

Attachment Policy 209.1

Optional Accommodations for Life Threatening Food Allergies – (To be completed by the parent):

Please circle Yes or No:

Yes No I will contact my child's teacher to schedule a conference to discuss my child's allergies.

Yes No I request that a sign/indicator of allergy be taped to the top of my child's desk as a visual reminder to staff. **We highly recommend this option. It is an additional safeguard if there would be a substitute teacher.**

Yes No I request that my child's teacher inform the students in the class of my child's allergies.

Yes No I request that my child sit at the nut-free table during lunch.

Yes No I permit my child to eat food sent by parents/ PTO members for celebrations (at your own risk). **We advise against this for safety reasons. We recommend that your child eat ONLY the safe snacks that YOU provide.** This safe snack from home may be kept in the classroom so that it is available as needed throughout the year.

Yes No Do you want your child to carry his/her own Epi-Pen?

Yes No Do you want an Epi-Pen in your child's classroom or a location other than the nurse's office? If so, please specify _____

Yes No Do you want an Epi-Pen on your child's bus? If so, please contact our transportation director at the bus garage to discuss your child's needs. The transportation director can be reached at (724) 654-2650.

Yes No Does your child have a history of an anaphylactic reaction to this allergen?

The parent agrees to the following:

Parent must initial:

_____ I agree to provide the Neshannock Township School District with the appropriate number of Epi-Pens and to note the expiration date so that upon expiration, I can replace them.

_____ I agree to provide the Neshannock Township School District with an alternative safe snack to be used in instances when food is brought in for classroom parties or birthday celebrations if necessary as indicated by parental choice above.

_____ In regard to field trip lunch arrangements, I agree to contact my child's teacher to discuss lunch arrangements at the destination. If necessary, I will pack a disposable tablecloths and sanitizing wipes to be used on field trips as I deem necessary.

_____ I agree to update my child's teacher and the school nurse as needed with any necessary changes in this plan or in my child's health status.

_____ I agree to provide the Neshannock Township School District with an allergy action plan (including a photo of my child) signed by my child's physician.

Parent Signature: _____ Date: _____

The teacher agrees to the following:

I have read and understand this document which contains the recommended procedures and accommodations regarding my student's allergy.

Teacher Signature: _____ Date: _____

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name _____ D.O.B. _____ Teacher _____

Student Photo

School Nurse Heather Collins Phone Number 724-856-4621-office
Health Care Provider _____ Preferred Hospital _____

History of Asthma No Yes-Higher risk for severe reaction

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening.			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
Antihistamine: Liquid Diphenhydramine (Benadryl®) _____ml. To be given by mouth *only if able to swallow.*
Other:

☐ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry an auto-injector.

Health Care Provider Signature _____ Phone: _____ Date _____

EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

Rev. 7/06
This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, AK Chapter

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan *(continued)* **Student Name** _____ **D.O.B.** _____

Each school will have 2 auto-injectors and liquid Diphenhydramine (Benadryl®) available during regular school hours. If your child participates in before or after school activities, your child will need to have an auto-injector on their person.

Parent/Guardian AUTHORIZATIONS

- ☐ I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.

X **Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.**

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Student Agreement:

- ☐ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- ☐ I agree to carry my auto-injector with me at all times;
- ☐ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when my auto-injector (epinephrine) is used;
- ☐ I will not share my medication with other students or leave my auto-injector unattended;
- ☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ **Date** _____

Approved by Nurse/Principal Signature: _____ **Date** _____

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis.

Critical components to prevent life threatening reactions: ☑ Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
X	Notify nurse, teacher(s), front office and kitchen staff of known allergies
X	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex reduced environment" sign at entrance of building
X	Encourage a no-peanut zone in the school cafeteria
X	Other: See Health Plan for accomodations

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By
Heather Collins	RN	Nurse Office	Self
Alexis Anderson	Counselor	Guidance	Heather Collins
Matt Heasley	Principal	Principal	Heather Collins

EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Rev. 7/06

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