LATHROP R-II SCHOOL DISTRICT

700 East Street Lathrop, Missouri 64465
www.lathropschools.com

"Whatever it takes to go from good to great!"

CHRIS FINE, SUPERINTENDENT
Phone: 816-740-3861 Fax: 816-528-7514

ROBERT BOWERS
High School Principal
Phone: 740-4502

ANDY MCNEELY
Middle School Principal
Phone: 740-3451

CHAUNCEY RARDON
Elementary School Principal
Phone: 740-3935

Dear Parent:

We are required to have the attached forms on file in the school district on any child who has a food allergy or any dietary restrictions. Please complete the forms, have your doctor sign them and return them to the school as soon as possible.

Thank You!

Lathrop R-II Health Room Staff

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Dear Parent/Guardian,

Please be aware of the **School District Food Allergy Guidelines** applicable for foods brought into or shared with the classroom. The guidelines outline specific requirements that must be complied with in order for food to be brought into the classroom. The guidelines provide clear and concise procedures in this area, and all faculty and administration are aware of these guidelines. However, it must be pointed out that while they are specific, the guidelines in and of themselves are merely guidelines. In other words, a situation can still occur where a non-compliant food item may enter the classroom and not be detected. While we hope this does not happen, we must still remain aware that it can. For this reason, we feel it necessary to make you aware of this possibility and advise that if you still have concerns in this area, you may want to provide your own child's snacks/treats for parties and other social events. Feel free to discuss your concerns and options with your child's teacher and/or health room staff.

Also, with this plan we will encourage designated seating in the cafeteria for our severe food allergy students. This area will be considered a "***safe zone***". Other classmates may sit in this area provided they are not consuming any allergen of concern. The most common severe allergy of our students is to nut products. Students having a school-prepared hot lunch are considered "safe" as OPAA does not serve foods prepared with nuts or nut products. Our "safe zone" requires a specific cleaning protocol to avoid cross contamination, which is another step in providing safety. Due to the above, we feel it is necessary to encourage the "safe zone" area for our severe allergy students.

☐ I have read the above and wish to have my child sit in the "Safe Zone" area with designated class mates.

☐ I have read the above and choose NOT to have my child sit in the "safe zone" area. I understand that by doing so, the risk that my child may be exposed to an allergen may be increased.

Child's Name: ____

Parent Signature: ______________________________ Date: ________________

Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
Telephone:	

For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

____

____

____

Diet Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan) ☐ Modified Texture and/or Liquids
☐ Reduced Calorie ☐ Food Allergy (describe): ____________________
☐ Increased Calorie ☐ Other (describe): ____________________

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment** ____________________

Additional comments: ____________________

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature	**Telephone Number**	**Date**
Signature of Preparer or Other Contact	**Telephone Number**	**Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian **Date**

Revised 6/99

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: __________

PLACE STUDENT'S PICTURE HERE

Allergy to: ______________________

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

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] **If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 asthmatic): ______________________

____

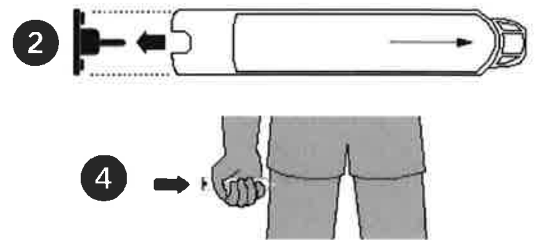
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

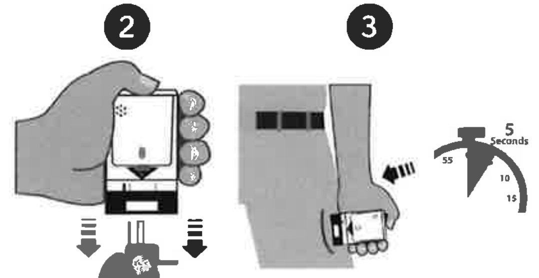
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 student 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) 8/2013