West Lafayette Community School Corporation
Food Allergy Protocol and Consent Form

It is the goal of West Lafayette Community School Corporation (WLCSC) to work in conjunction with students and their families to facilitate a safe educational environment utilizing a realistic approach to food allergy management.

When planning for food allergy needs, the WLCSC protocol takes into consideration the following:

- The academic buildings may be used after school hours for extra -curricular activities and community events
- Common areas of the building are used for instruction of a majority of the student population
- Students in grades K – 6 primarily eat lunch in the cafeteria
- Students in grades 7 -12 are allowed to eat in areas other than the cafeteria, including hallways and classrooms. Student groups meet during lunch, oftentimes in classrooms. West Lafayette Junior-Senior HS has an open campus during the lunch periods.
- Most extra -curricular activities involve food ranging from individual to team snacks and/or meals. Food is often eaten on the bus in transit to or from competitions.
- Some curriculums involve food preparation. No student is required to eat food brought from another's home.

Parent/Guardian Responsibility:

- Inform school of allergy and treatment plan/ provide medical documentation as requested
- Supply emergency medications (epi pen, auvi-Q, Benadryl, etc) for student
- Complete appropriate consent forms signed by parent and doctor
- Indicate if student will self- carry and self –administer emergency medications per appropriate consent forms
- Maintain updated emergency contact information for self and alternate
- Provide alternative "safe snacks" for student at school, if indicated

School Procedure:

- Emergency medications will be accessible in central location such as nurse's office
- Staff will be educated on emergency medication administration
- Emergency action plan will be in place for each student
- A nut free table will be available in the cafeteria. The nut free table is positioned within the general population of the cafeteria. Students with a diagnosed nut allergy may eat lunch at this designated table provided he/she eats a school lunch or has no nut products within lunch from home. Each K-6 nut allergic student may invite a friend to sit at the table provided the non-allergic friend eats a school lunch. The non- allergic friend may not sit at the designated table if he/she brings a lunch from home.
- K-6 classrooms will be nut controlled
- K – 6 common areas will have reminder signs as nut controlled zones

WLCSC STRONGLY RECOMMENDS THAT K – 6 NUT ALLERGIC STUDENTS EAT LUNCH AT THE AVAILABLE "NUT FREE" TABLE. THIS RECOMMENDATION IS MADE WITH THE SAFETY OF YOUR STUDENT IN MIND. Students seated at this table are readily identifiable and the lunch supervisors are aware of their needs. As students are not assigned seats, the nut allergic student may sit with students, who buy a school lunch, of his/her choosing at the assigned "nut free" table in the cafeteria. That table may change from day to day. Students at this table shall not share food.

- o I, as the parent/guardian of _____, consent to having my child sit at the "nut free" table, until the undersigned advises to the contrary, and I will comply with the abovementioned protocol.
- o I, as the parent/guardian of _____, do not consent to my child sitting at the "nut free" table, however, I have read the Parent/Guardian Responsibility and agree to comply with those protocols.

_____
Parent/Guardian

Responsibilities of the Parent/Guardians/Family members of a student with food allergies

_____inform the school nurse and/or principal of your child's allergies prior to the beginning of the school year, or as soon as possible after a diagnosis

_____submit all medication consent forms (physician ordered and over-the-counter) by the first day of class

_____provide the nurse with the Food Allergy Action Plan completed by student's physician

_____provide the nurse with all medications necessary for school administration

_____provide the school with updated emergency contact numbers and medical information, this includes cell phone, home phone, work phone and two emergency contacts' telephone numbers.

_____be willing to provide "safe snacks" for your student to keep in the classroom so there will always be something your child can choose if necessary

_____be willing to go on your student's field trips if requested

_____provide a list of foods and ingredients to avoid

_____periodically teach your child the first symptoms of an allergic/anaphylactic reaction

_____encourage your child to communicate clearly to an adult if he/she feels a reaction is starting

_____instruct your child to not share food with anyone

_____teach the importance of hand washing before and after eating

_____report any teasing or bullying to an adult authority

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) 3/2016

PRESCRIPTION MEDICATION

PHYSICIAN PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

2016-17

COMPLETED BY PHYSICIAN – COMPLETED BY PHYSICAN – COMPLETED BY PHYSICIAN – COMPLETED BY PHYSICAN

Name of Student _____

Please indicate which school your patient attends:

☐ Cumberland
Nurse (765) 269-4105
Fax (765) 464-3210

☐ Happy Hollow Elementary
Nurse (765) 269-4304
Fax (765)746-0507

☐ WL Jr / Sr High School
Nurse (765) 746-0419
Fax (765) 746-0466

I authorize the above named school to administer the following medication:

Medication	Route	Dose	Frequency	Duration (Dates)

Physician's Signature _____

Physician's Printed Name _____

Parent signature required in order to dispense above medication

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ (Signature of Parent / Guardian)

_____ (Date)

The above signature acknowledges that the school corporation and its employees assume no responsibility or liability for the prescription of medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with the instructions set forth above. The above signed further, both individually and as a parent and/or guardian of the above named child, does hereby waive and release any claim against the West Lafayette Community School Corporation or its employees resulting from the administering of such medication in accordance with the instructions set above.

_____ School Nurse

_____ Date received by Nurse

West Lafayette Community School Corporation, 1130 North Salisbury Street, West Lafayette, IN 47906 (765) 746 - 1602

OVER-THE-COUNTER MEDICATION

PARENT PERMISSION FORM

2016-17

Student Name _____ Grade _____ Teacher _____

- Please fill out this form for any over-the-counter medication you want given to your child
- Please indicate the medication, dosage, frequency, and dates to be given
- Medications must be in the **ORIGINAL CONTAINER**
- **STUDENTS MAY NOT**
  - **BRING MEDICATIONS TO SCHOOL OR**
  - **CARRY MEDICATIONS HOME FROM SCHOOL.**
- Medications must be transported to and from school by parent / guardian
- **PARENT / GUARDIAN SIGNATURE IS REQUIRED** in order to dispense over-the-counter medications

Form below must be filled out completely to be valid

Medication	Dosage	When to give during day	Reason for taking the medication	Dates to be given

Signature of parent / guardian required for medication to be dispensed

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ _____

(Signature of Parent/ Guardian) (Date)

The above signature acknowledges that the school corporation and its employees assume no responsibility or liability for the prescription of medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with the instructions set forth above. The above signed further, both individually and as a parent and/or guardian of the above named child, does hereby waive and release any claim against the West Lafayette Community School Corporation or its employees resulting from the administering of such medication in accordance with the instructions set above.

_____ _____

School Nurse Date received by Nurse

West Lafayette Community School Corporation, 1130 North Salisbury Street, West Lafayette, IN 47906

Cumberland
Nurse: (765) 269 - 4105
Fax: (765) 464 - 3210

Happy Hollow Elementary
Nurse: (765) 269-4304
Fax: (765) 746-0507

WL Jr / Sr High School
Nurse: (765) 746 - 0419
Fax: (765) 746 - 0422