TOOELE COUNTY SCHOOL DISTRICT
HEALTH CARE PLAN
COVER SHEET

Student's Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Parent/Guardian: _____ **Phone:** _____

Address: _____

Other Emergency Contacts: #1) _____
Name **Phone**

#2) _____
Name **Phone**

Is student in Resource or Special Ed? ☐ **yes** ☐ **no**
Does student ride the bus? ☐ **yes** ☐ **no Bus #____**

Doctor's Name: _____

Telephone #: _____ **Fax #:** _____

Medical Diagnosis: _____

- ☐ **Student will carry/self administer medication**
- ☐ **School staff will store and administer medication**
- ☐ **No medication is required**

Medication and/or medical supplies will be located at:

- ☐ **Office**
- ☐ **Student's desk**
- ☐ **Locker**
- ☐ **Teacher's desk**
- ☐ **Student's backpack**
- ☐ **Other** _____

I have read and approve student's healthcare plan.

_____ _____
Principal **Date** **School Nurse** **Date**

_____ _____
Teacher/School Staff **Date** **Teacher/School Staff** **Date**

_____ _____
Teacher/School Staff **Date** **Teacher/School Staff** **Date**

ANAPHYLAXIS – HEALTH CARE PLAN

Student's Name: _____

This Health Care Plan and the appropriate Utah Department of Health Epinephrine Auto Injector(EAI) Medication Form must be completed by the student's parent/guardian and/or their health care provider and returned to the school nurse or the school secretary. (The Health Care Plan should be individualized to meet the student's specific needs.)

Anaphylaxis is a serious allergic reaction that is rapid in onset and can close off the student's breathing passages. If immediate treatment does not occur, anaphylaxis can be fatal.

Problem: Breathing difficulty
Goal: Known anaphylaxis allergens (triggers) will be avoided and the student's airway will be maintained.
A**ction:** The student will avoid, and school personnel will assist student in avoiding, all known anaphylaxis triggers. (The student's parent/guardian and/or their health care provider will check the appropriate boxes below.)

1. The student should avoid the following anaphylaxis triggers in any form, including skin contact:
   - ☐ Peanuts
   - ☐ Tree nuts
   - ☐ Milk
   - ☐ All dairy
   - ☐ Eggs
   - ☐ Shellfish
   - ☐ Fish
   - ☐ Food additives (list):_____
   - ☐ Insect stings (list): _____
   - ☐ Medication (list): _____
   - ☐ Others (list): _____
   - ☐ Others (list): _____
2. The student's anaphylaxis symptoms are as follows and usually have a rapid onset:
   - ☐ Change of voice
   - ☐ Cold, clammy, sweaty skin
   - ☐ Coughing or choking
   - ☐ Difficulty breathing or swallowing
   - ☐ Dizziness, confusion
   - ☐ Fainting or loss of consciousness
   - ☐ Feelings of apprehension
   - ☐ Feeling of the throat "closing off"
   - ☐ Flushed face or body
   - ☐ Hives
   - ☐ Itching
   - ☐ Swelling (eye, lips, face, tongue)
   - ☐ Shallow respirations
   - ☐ Stomach cramps, diarrhea
   - ☐ Sweating
   - ☐ Tingling sensation in the mouth, face, or throat
   - ☐ Vomiting
   - ☐ Weakness
   - ☐ Wheezing
   - ☐ Others (list): _____
3. If the student experiences any of the above symptoms, they should notify someone immediately.
4. If school personnel recognizes the student is experiencing anaphylaxis symptoms, they must initiate the treatment as outlined below.
   - ☐ The student's medication(s) must be administered as directed by their health care provider.
   - ☐ 911 MUST BE CALLED IMMEDIATELY!! The dispatcher should be informed that a child is having a life-threatening anaphylactic reaction.
   - ☐ The parent/guardian and/or emergency contact and the school nurse should then be notified.
   - ☐ CPR MUST BE ADMINISTERED IMMEDIATELY IF THE STUDENT STOPS BREATHING.

Additional information: _____

_____

_____

Medical Statement to Request Special Meals, Accommodations, and Milk Substitutions

1. School/Agency	2. Site	3. Site Manager & Telephone Number
4. Name of Student		5. Age or Grade
6. Name of Parent or Guardian		7. Telephone Number

8. Check One Box:

☐ Student has a disability which *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) A *licensed medical physician* must sign this form.

☐ Student does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs *may* accommodate reasonable requests. A *licensed medical physician, physician's assistant, registered nurse, nurse practitioner, or registered dietitian* must sign this form.

☐ The student does not have a disability. A fluid milk substitution is being requested for the student. Schools and agencies participating in federal nutrition programs *may* choose to accommodate this request by providing a USDA approved fluid milk substitute. A *licensed medical physician, physician's assistant, registered nurse, nurse practitioner, registered dietitian, parent, or guardian* must sign this form.

9. State the disability or medical condition requiring a special meal, accommodation, or fluid milk substitute.

10. If student has a disability, provide a brief description of the major life activity affected by the disability.

11. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.)

12. Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Specific foods to be omitted and substituted. You may attach a sheet with additional information.

A. Foods to be Omitted	B. Foods to be Substituted

14. Adaptive Equipment Needed:

15. Signature of Preparer	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority and Credentials	20. Printed Name	21. Telephone Number	22. Date

23. To be completed by the LEA/School: ☐ Additional information needed ☐ Approves request ☐ Denies request

LEA Comments:

This information may be shared with the school nurse or other administrative staff to accommodate the student in all school activities.

Medical Statement to Request Special Meals, Accommodations, and Milk Substitutions

Instructions

This form must be kept on file at the school site. The following instructions are provided to assist in completing this form. If you have specific questions, please contact Kimi Sycamore, RD at 801-974-8380

8. Check One: Check (√) a box to indicate whether a participant has a disability, non-disability, or need for a fluid milk substitute. The appropriate authority must sign based on the request.

9. State Disability or medical condition requiring a special meal, accommodation, or fluid milk substitute: Describe the medical condition that requires a special meal, accommodation, or fluid milk substitute (e.g., juvenile diabetes, allergy to peanuts, PKU, etc.)

10. If Student has a disability, provide a brief description of the major life activity affected by the disability: Describe how the physical or medical condition affects the disability. For example, "Allergy to peanuts causes a life-threatening reaction."

11. Diet prescription and/or accommodation: Describe a specific diet or accommodation that has been prescribed by a physician, or describe the diet modification requested for a non-disabling condition. For example, "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."

12. Indicate texture: Check (√) a box to indicate the type of food texture required. If no texture modification is needed, check regular.

13. Specific foods to be omitted and substituted: List specific foods to be omitted and substituted. Attach a sheet with additional information if needed.

Foods to be Omitted: List specific foods to be omitted. For example, "peanut butter"

Foods to be Substituted: List specific foods to be substituted. For example, "peanut free soy butter or SunButter®."

14. Adaptive Equipment Needed: Describe specific equipment required to assist the participant with dining. Examples could include: Sippy cup, large handled spoon, wheel-chair accessible furniture, etc.

Definitions

A Person with a Disability- any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or Mental Impairment-(a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitor-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major Life Activities-functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Record of Impairment-having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

***Citations from Section 504 of the Rehabilitation Act of 1973**

USDA Guidelines for Accommodating Special Dietary Needs

Disability-Schools and agencies participating in federal nutrition programs **must** comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.

Non-disability-Schools and agencies participating in federal nutrition programs **may** comply with requests for non-disabling medical conditions. Accommodations will be made on a case-by-case basis. However, if accommodations are made for a specific medical condition, complete requests for the same medical condition must be accommodated.

Fluid Milk Substitutions-Fluid milk substitutions apply to non-disability requests. Schools and agencies participating in federal nutrition program **may** accommodate complete requests with a USDA approved non-milk equivalent. If accommodations are made for one student requesting a fluid milk substitute, accommodations must be made for all students requesting a fluid milk substitute.

This information may be shared with the school nurse or other administrative staff to accommodate the student in all school activities.

Date _____

Utah Department of Health/Utah State Office of Education
Epinephrine Auto Injector(EAI) Medication Form
In Accordance with Utah Code 53A-11-603 and 26-41, HB 101, 2008 General Session

_____
Student Name Birth Date

_____
Address City State Zip

EMERGENCY CONTACT INFORMATION:

Name _____ Phone _____

Health Care Provider Authorization

The above named student is under my care. I feel it is medically appropriate for the student to self-administer Epinephrine Auto Injector(EAI) medication, when able and appropriate, and be in possession of EAI medication and supplies at all times. The medication prescribed for this student is:

Name of Medication _____

Dosage _____

Possible Side Effects _____

_____
Signature of Health Care Provider Date

Parent/Guardian Authorization (mark all that apply)

☐ I authorize my child _____ to carry prescribed Epinephrine Auto Injector (EAI) medication and supplies.

☐ I authorize the appropriate/designated school personnel maintain my child's medication for use in an emergency.

☐ I authorize my child to self administer and carry the prescribed medication described above consistent with In Accordance with Utah Code 53A-11-603 and 26-41, HB 101, 2008 General Session

☐ I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

My child and I understand there may be serious consequences, including suspension/expulsion from school, for sharing any medications and/or supplies with other students or school staff.

Parent/Guardian Signature Date

Date _____

Epinephrine Auto Injector (EAI) Authorization Form

In Accordance with Utah Code 53A-11-603 and 26-41, HB 101, 2008 General Session

Name of Student _____Date of Birth _____

Name of School _____ Grade _____

I _____ parent/guardian (circle one) of above student certify that the epinephrine auto injector has been prescribed for him/her. I request that the student's public school identify and train school personnel who volunteer to be trained in the administration of Epinephrine Auto Injector (EAI) medication in accordance with Utah Code 53A-11-603 and 26-42, HB 101, 2008 General Session. I authorize the administration of Epinephrine Auto Injector(EAI) medication in an emergency to the identified student in accordance with Utah Code 53A-11-603.

Parental Responsibilities:

- The parent or guardian is to furnish the Epinephrine Auto Injector(EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector(EAI) medication within two weeks if the Epinephrine Auto Injector(EAI) single dose medication is given.
- If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector(EAI) Authorization Form before the designated staff can administer the updated Epinephrine Auto Injector(EAI) medication prescription.
- The parent or guardian will complete, sign and deliver an Epinephrine Auto Injector(EAI) Medication Form if the student is to possess Epinephrine Auto Injector(EAI) medication at all times.

I give my permission for the school nurse or school designee to contact my child's healthcare provider if clarification is needed to administer Epinephrine Auto Injector(EAI). I agree to meet the parental responsibilities listed above. ***I give my permission for school personnel to release personal or medical information about my child in a health-related emergency situation if necessary.*** *I understand this completed and signed form authorizes designated school personnel to administer epinephrine in emergency situations consistent with Utah Law.*

Parent Signature _____ Date_____

Parent Phone Number _____ Parent Emergency Number _____