Student Allergy Medical Plan of Care for Newton County School System Nurses and the School Nutrition Program

Part 1: To be completed by Parent/Guardian

Child's Name		Date of Birth	M F
Name of School		Grade Level/Classroom	
Parent's/Guardian's Name		Address, City, State, Zip Code	
( ) Home Phone	( ) Work Phone		

Part 2: To be completed by a Physician
Signs of an Allergic Reaction include (Circle student's usual symptoms):

List food allergies:_____

List non-food allergies (such as pollen, etc.) _____

MOUTH: itching and swelling of the lips, tongue or mouth

THROAT: itching and/or a sense of tightness in the throat, hoarseness and hacking cough

SKIN: hives, itchy rash and/or swelling about the face or extremities

GI TRACT: (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea

LUNGS: shortness of breath, repetitive coughing and/or wheezing

HEART: weak and "thread" pulse, "passing out"

ACTION:
1. If ingestion, exposure, or sting is suspected, give_____
(medication, dose, route)
and _____ immediately.
(other actions to be taken)

2. Call 911 or local Emergency Medical Services.

3. Call: Mother/Guardian: Phone #_____ Father: Phone# _____

Cell Phone #:_____ Cell Phone#: _____

Other Emergency Contact:_____

Note: A physician's signature is required if medication is needed to treat allergic reactions.

Check here if no medication is needed. ☐

Part 3: To be completed by Physician/Medical Authority
Disability/Special Dietary Needs:

Does the child have a disability that affects his or her nutritional or feeding needs?* Yes ☐ No ☐

*Food Allergies which result in conditions that impair immune, digestive, neurological, and bowel functions, etc. Most physical and mental impairments that can result from a food allergy are considered a disability.

If the child does not have a disability*, does the child have special nutritional or feeding needs? Yes ☐ No ☐
If you answered Yes to either of these questions, complete Part 4:

Part 4: To be completed by Physician/Medical Authority
Diet Order:

List any dietary restrictions, such as food allergies or intolerances. Specify which foods are to be omitted:

Part 5: To be completed by Medical Authority or Parent/Guardian
Fluid Milk Restriction:

Does the child have a special dietary need that restricts intake of fluid milk? Yes ☐ No ☐

If so, list medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

If the child has a lactose intolerance, would you like for School Nutrition to provide lactose free milk?
Please note: School Nutrition can only acquire plain, non-flavored lactose-free milk. Yes ☐ No ☐

Physician/Medical Authority Printed Name and Office Phone Number		**Address or Office Stamp**
Physician/Medical Authority's Signature		**Date**
Parent/Guardian Signature		**Date**

Health Insurance Portability and Accountability Act Waiver
In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (Physician/Medical Authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to Newton County School System and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ **Date:**_____
(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

Any changes may require submission of a new form signed by the Physician/Medical Authority.

OFFICE USE ONLY:

Date and Details of Adjustments to Diet Order:

A copy of this form should be kept by the School Nutrition Manager and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school nutrition services.