School Nutrition Eating and Feeding Modifications School Year _____

EATING AND FEEDING EVALUATION FORM: must be completed and signed by a Physician if your student requires a dietary restriction. (i.e. no peanut butter, no strawberries, etc.) OR a food substitute (i.e. allergic to cow's milk – substitute soy milk). This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.) This form is good for one school year. It must also be completed and signed by student's Physician to reverse a previous accommodation (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)

PART A			
Name of Student:		**Date of Birth:** _____ / _____ / _____	
Allergies:			
Name of School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? If Yes, describe the major life activities affected.		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? **If Yes, Part B of this form must be completed and signed by a licensed Physician.**		☐ **Yes**	☐ **No**
IF STUDENT DOES NOT REQUIRE SPECIAL MEALS, PARENT/GUARDIAN CAN SIGN AT THE BOTTOM OF THIS FORM AND RETURN THE FORM TO THE SCHOOL'S FOOD SERVICE.			
PART B			
List any dietary restrictions or special diet:			
List any allergies or food intolerances to avoid:			
List foods to be substituted:			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite-size pieces: **Finely ground:** **Pureed:**			
List any special equipment or utensils that are needed:			
Indicate any other comments about student's eating or feeding patterns:			
Parent/Guardian's Signature: _____		**Date:** _____ / _____ / _____	
Physician's Signature: _____		**Date:** _____ / _____ / _____	

For School Use Only—Copy to be filed in student health file, school nutrition file and exceptional children file if applicable

Reviewed by: _____ Date: _____ Copy Sent to: [ ] Health Services [ ] School Nutrition [ ] Exceptional Children

Physician diagnosed disability/special need [ ] Has IEP or 504 [ ] Needs IEP or 504 Evaluation

District Health Services Allergy Action Plan [ ] Has IHP [ ] Needs IHP

Anaphylaxis (Severe Allergic Reaction) Individual Health Plan School Year: _____ Grade: ___

Student Name_____DOB_____ Picture
Parent/Guardian_____Phone_____
Emergency Contact_____Phone_____
Treating Physician_____Phone_____

Allergy to:_____ Dx of Asthma? ❒Yes ❒No

Severity Classification
- ❒ Mild Intermittent
- ❒ Mild Persistent
- ❒ Moderate Persistent
- ❒ Severe Persistent

Triggers
- ❒ Peanuts
- ❒ Tree nuts
- ❒ Shellfish
- ❒ Latex
- ❒ eggs
- ❒ milk
- ❒ medication
- ❒ animals
- ❒ Insect Stings (list)_____
- ❒ All dairy
- ❒ fish
- ❒ other _____

School Nutrition Modification Evaluation Form Must Be Completed by Prescribing Physician For ALL Dietary Modifications

Mild to Moderate Allergic Reaction

- ❒ minor swelling of lips, face, eyes
- ❒ hives or welts
- ❒ abdominal pain
- ❒ vomiting

Action: Stay with child and call for help from health unit; give medication (if prescribed); & immediately contact parent/guardian

Medication: MD-Please Specify

❒Antihistamine: _____

Anaphylaxis—Severe Reaction or No Improvement

- ❒ difficulty/noisy breathing
- ❒ swelling of tongue
- ❒ cold, clammy, sweaty skin
- ❒ swelling/tightness in throat
- ❒ pale and floppy (young children)
- ❒ flushed face
- ❒ difficulty talking and/or horse voice
- ❒ loss of consciousness

Administer Medication & Call 911

❒**Epinephrine** _____
(via auto injector unless otherwise specified)

Location of medication: ❒ Health Unit ❒ Emergency Action Medication must be with student at all times, *either on their person or with an accompanying adult*

Administration of medication: ❒ School Nurse or trained unlicensed school personnel ❒ Self administration with adult supervision

❒ **Independent Self Administration**—it is my professional opinion that this student is able to carry above prescribed medication with them at all times—during the school day, on field trips, and while participating in before or after school clubs/events/athletics. He/she has been instructed on the indication for medication usage and the method of administration.

Please Note: *The school nurse does not always attend field trips or after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication. Student authorized for independent self administration of medication are not monitored by school staff, however school staff are available for emergency response during all school sponsored activities.*

Prescription medication or treatment daily at school / at home for this condition: _____

During a field trip, scheduled daily medication:
- ❒ requires a trained staff member to administer medication
- ❒ is authorized to carry and self administer medication

X _____ _____ _____

Physician or Authorized Healthcare Provider Signature ***Telephone Number*** ***Date Signed***

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other staff members that have direct contact with my child for the current school year. I understand that a trained school staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school health unit shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school.

I hereby agree to release and hold staff members free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____

Parent/Guardian Signature ***Date Signed***

Other Health Condition Individual Health Plan School Year: _____ Grade: ___

Student Name_____ DOB_____
Parent/Guardian_____ Phone_____
Emergency Contact_____ Phone_____
Treating Physician_____ Phone_____

Picture

Type of Health Condition:

- ❒ Migraines
- ❒ Stomach/Bowel
- ❒ Metabolic Disorder
- ❒ Immune Disorder
- ❒ Cardiac / Heart
- ❒ Cancer
- ❒ Blood Disorder
- ❒ Joint or Bone

Other—Please Specify

Known Triggers: Please Specify

Symptoms of Health Crisis: (What to look for at school)

ACTION:
1. Administer Medication as prescribed
2. Other: _____
3. Contact the parent/guardian as per their instructions: _____

Emergency Procedures: If student is unconscious or in severe crisis call for EMS.

CALL 911

OVER THE COUNTER MEDICATIONS AUTHORIZED BY PARENT/GUARDIAN Parents MUST provide all medications and supplies.

My child requires over-the-counter medication **provided by me**, the undersigned parent/guardian, as needed for symptoms of his/her diagnosed health condition DESCRIBED IN DETAIL ABOVE.

OTC Medication: _____ Dosage: _____
OTC Medication: _____ Dosage: _____

Prescription Emergency Medication: _____

Location of medication: ❒ Health Unit ❒ Emergency Medication must be with student at all times, or with an accompanying adult

Please Note: *The school nurse is not always available on field trips or during after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication.*

Prescription medication or treatment daily <u>at school</u> for this condition: _____

Prescription medication or treatment daily <u>at home</u> for this condition: _____

During a field trip, scheduled daily medication:
- ❒ requires a trained staff member to administer medication
- ❒ is authorized to carry and self administer medication

X _____ _____ _____

Physician or Authorized Healthcare Provider Signature ***Telephone Number*** ***Date Signed***

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self administered is not monitored by school staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school health unit shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school.

I hereby agree to release and hold staff members free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____

Parent/Guardian Signature ***Date Signed***