PARENT WAIVER AND UNDERSTANDING OF FOOD ALLERGY POLICY
ARCHDIOCESE OF ATLANTA

STUDENT _____ **GRADE**_____

SCHOOL _____ **SCHOOL YEAR** _____

Parents' signatures on this document indicate their receipt of this policy and their understanding of the school's efforts to provide and address food allergy issues and to reasonably provide a safe environment for their child. There is no promise or guarantee of success, but rather a commitment to these reasonable measures. Please initial the line below each of the listed measures to indicate your preference for having that measure implemented for your child.

_____ **School reaffirms its commitment to providing a safe and welcoming environment for all students. Students will not be excluded from school activities based solely on a food allergy provided that a safe, reasonable accommodation is available.**

Measure the school may make available and implement for students with food allergies:

1. A yearly meeting will be held with the parents, student (age appropriate), a representative of the school administration, school nurse, and teacher to determine reasonable measures from the list below. These measures will be implemented for the purpose of providing a prevention plan for the student throughout the school year. The Parent Waiver and Understanding of the Food Allergy Policy is completed at this meeting.
2. The school will ask the family yearly to have their child's physician complete the Food Allergy Action plan with specific instructions regarding the student's food allergy and recommendations for emergency treatment.

   _____
3. A letter will be sent at the beginning of the year to all parents in the appropriate grade level informing parents of the existence of a food allergy in their child's grade.

   _____
4. The student's classroom will be designated as a food allergy-free classroom zone. The school will make reasonable attempts to ensure that offending allergens are not present in the classroom. However, the school cannot guarantee that these allergens will not be present. The removal of allergens will include food used in lesson plans, crafts and holiday parties. Any child in the affected grade level who inadvertently brings to school a product for a snack that contradicts the food allergy notification sent by the principal must exchange it for a snack that is safe. Parent contact by the teacher should occur as a follow-up.

   _____
5. The school will designate a table within the cafeteria as a food allergy-free zone table.

   _____
6. The designated food allergy-free zone table will be separate from the other tables and will be used by students with food allergies and designated friends (see #8 below) in the cafeteria.

   _____
7. The allergen-free zone lunch table will be wiped down before each lunch period using sanitizer recommended by the CDC/FAAN, etc. for removal of food allergens on tabletops. Such cleaners may include 409, Lysol sanitizing wipes or Target brand cleaner with bleach.

All three products have been found to remove peanut allergens, in particular from tabletops (Tamara, Conover-Walker, Pomes, Chapman & Wood, 2004).

8. The student with a food allergy will have an opportunity to choose 2-3 friends with whom to sit during lunch. The students chosen to sit at the food allergy-free zone table will have their lunches checked by the teacher or monitor on duty or the classroom teacher before lunch.

9. All students will be encouraged not to trade or share food or food utensils.
10. Students who may bring a food allergy product at lunchtime are encouraged to wash their hands before recess and/or before returning to the classroom.
11. School staff will receive training on the allergen labeling requirements and will be given a how-to-read label sheet.
12. School staff will receive training on recognizing symptoms of anaphylaxis from food allergies.
13. School staff will receive training in non-medical personal treatments for anaphylaxis from food allergies.
14. Epi-pens (with required documentation from the physician) will be placed in several key locations in the school building in the event school staff needs to treat a child for an allergic reaction. An epi-pen will be part of the first aid kit that will be taken on all field trips for this grade level. School staff will receive training on how to effectively handle these situations.
15. In the event that epinephrine is administered, 911 will be called and the child will be transported by EMS to the hospital.
16. As part of their training, substitute teachers will be informed of these policies and protocols. Classroom teachers will also include reminders of students that have food allergy as part of their substitute plans.
17. Other as agreed upon by school, parents, and student's health care provider:

    _____
    _____
    _____

I/we agree to work cooperatively with the school and its personnel to address my child's food allergy and to find reasonable measures to implement a safe environment. I/we further understand and acknowledge, however, that despite such efforts, neither the school nor the Archdiocese of Atlanta can absolutely guarantee my/our child will not come into contact with a food allergen and, that in event such contact does occur, the school and the Archdiocese of Atlanta expressly deny any responsibility or liability for the same.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
School Representative Date

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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 allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG — Shortness of breath, wheezing, repetitive cough

HEART — Pale or bluish skin, faintness, weak pulse, dizziness

THROAT — Tight or hoarse throat, trouble breathing or swallowing

MOUTH — Significant swelling of the tongue 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 emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE — Itchy or runny nose, sneezing

MOUTH — Itchy mouth

SKIN — A few hives, mild itch

GUT — Mild nausea or 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 or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

For Preschool Year:_____ **MEDICAL / ALLERGY ACTION PLAN**

Child's first and last name: _____ D.O.B._____ Age____

Diagnosed Condition:_____

Please describe SYMPTOMS OF MEDICAL EMERGENCY
may continue on back of page

Body Area:	Mild	Moderate	Severe	Give describe specific details:
Mouth				
Tongue				
Skin				
Intestinal				
Breathing (Lung)				
Heart				
Other:				

TREATMENT PLAN:
Indicate priority of treatment with **1st**, **2nd**, **3rd** and/or **4th**.

If any box is **not applicable** to your child's needs, please write **N/A** in box.

	Call 911- Administer EPI PEN / Rescue Inhaler (**circle** appropriate medication - provided by parent and medication form on file)
	Administer Rescue Inhaler and call parent.
	Give OTC medication and call parent. (provided by parent and medication form on file)
	No medication is necessary, Call parent and observe child.

EMERGENCY PHONE NUMBERS

For the safety of my child, I authorize The Preschool at All Saints to put this "Action Plan" into place. I will provide, in writing, any medical changes, change in phone numbers and list other adults (additional to parents), who are authorized to provide medical information about my child. I will replace medication before expiration date.

Parent Signature:_____ **Today's Date:**_____

The following persons, after parents, should be called if an emergency arises at preschool and we cannot contact a parent. The following persons also have permission to pick up my child from preschool. eg: Grandparents or other relatives, nanny, neighbors, etc.

You must list ONE in addition to parents, two or more names are preferred.

	First and Last name of person	Relationship to Child	Cell Number
#1			
#2			
#3			
#4			
#5			

Parent/Director Medical/Allergy Meeting

Director/Parent complete this form together.
Documentation and CLASSROOM MANAGEMENT:

Director, after discussing with parent, please check all that apply. Write **N/A** if not applicable for child.

Notes:

Name of Allergen / Irritant OR Medical Diagnosis(circle):_____

	OK for other classmates to have.
	Child sits away from Allergen/Irritant.
	Food / irritant should not be allowed in classroom.
	Ingesting allergen causes reaction.
	Touching allergen causes reaction.
	Inhalation of allergen causes
	Child uses daily medical equipment. Please List:
	Used Indoor / Outdoor. (pls. circle)
	Used Both Indoor and Outdoor.

	Dr. Medical Note on file.
	Current Meds in office/classroom. Expiration Date:
	Copy of all documents in Child's folder.
	Copy of all documents in School Emergency Notebook.
	Copy of all documents in Teacher/Classroom Emerg. Notebook.
	Current classroom teachers have been given Orientation regarding these Medical/Allergy needs.
	STAPLE this form with current Medical/Allergy Plan Epi Pen procedures.

Archdiocese of Atlanta
Office of Catholic Schools

Medical Exemption Statement

Physician: Please mark the true contraindications/precautions that apply to this patient, then sign and date the back of the form. The signed Medical Exemption Statement verifying true contraindications/precautions is submitted to and accepted by schools, child care programs and other agencies that require proof of immunization. This signed form does not require approval from the State Health Director. For medical exemptions for conditions not listed below, the physician must submit a Physician's Request for Medical Exemption in writing to the State Health Director for approval.

Attach a copy of the most current immunization record.

Name of Patient_____ DOB_____

Name of Parent/Guardian_____

Address (patient/parent)_____

_____

School/Child Care_____

Medical contraindications for immunizations are determined by the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), Public Health Services, U.S. Department of Health and Human Services, published in the Centers for Disease Control and Prevention publication, the Mortality Weekly Report.

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication is present.
A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present.

True Contraindications and True Precautions

Vaccine	X	
General for all Vaccines		**Contraindications**
	☐	♦ Serious allergic reaction (i.e. anaphylaxis) after a previous vaccine dose: document vaccine _____
	☐	♦ Serious allergic reaction (i.e. anaphylaxis) to a vaccine component: document component _____
	☐	♦ Document type of reaction _____
		Precautions
	☐	♦ Moderate or severe acute illness with or without fever
DTaP		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
	☐	♦ Encephalopathy within seven days after receipt of previous dose of DTP or DTaP
	☐	♦ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized
		Precautions
	☐	♦ Fever greater than 40.5°C (104.9°F) ≤48 hours after vaccination of previous dose of DTP or DTaP
	☐	♦ Hypotonic-hyporesponsive episode≤48 hours after vaccination of previous dose of DTP or DTaP
	☐	♦ Seizure within 72 hours after vaccination of previous dose of DTP or DTaP
	☐	♦ Persistent, inconsolable crying lasting three hours or more ≤48 hours after receiving a previous dose of DTP or DTaP
	☐	♦ Moderate or severe acute illness with or without fever
DT, Td		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
		Precautions
	☐	♦ Guillain-Barré syndrome ≤6 weeks after a previous dose of tetanus toxoid-containing vaccine
	☐	♦ Moderate or severe acute illness with or without fever

Vaccine	X	
EIPV		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
		Precautions
	☐	♦ Pregnancy
	☐	♦ Moderate or severe acute illness with or without fever
Hepatitis B		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
		Precautions
	☐	♦ Infant weighing <2,000 grams if mother is documented hepatitis B surface antigen (HbsAg)-negative at the time of the infant's birth
	☐	♦ Moderate or severe acute illness with or without fever
Hib		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
	☐	♦ Age <6 weeks
		Precautions
	☐	♦ Moderate or severe acute illness with or without fever
MMR		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
	☐	♦ Pregnancy
	☐	♦ Known severe immunodeficiency (e.g. hematologic and solid tumors or severely symptomatic human immunodeficiency virus [HIV] infection)
		Precautions
	☐	♦ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)
	☐	♦ History of thrombocytopenia or thrombocytopenic purpura
	☐	♦ Moderate or severe acute illness with or without fever
Varicella		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component
	☐	♦ Substantial suppression of cellular immunity
	☐	♦ Pregnancy
		Precautions
	☐	♦ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)
	☐	♦ Moderate or severe acute illness with or without fever

Attach most current immunization record.

Date exemption ends_____

_____

Physician's Name *(please print)*

Address_____

_____

Phone_____

_____

Physician's Signature/Date

Instructions

Purpose:

To provide physicians with a mechanism to document <u>true</u> medical exemptions.

Preparation:

1. Complete patient information (name, DOB, address and school/child care.)
2. Check applicable vaccine(s) and exemption(s).
3. Complete date exemption ends and physician information.
4. Attach a copy of the most current immunization record.
5. Retain copy for file.
6. **Return original to person requesting form.**