Campus_____ Attach Photo Here

Northside Independent School District
2012-2013
Food Allergy/Special Dietary Needs/Disability Action Plan
Physician Order Form

Name: _____ Student ID #: _____ D.O.B. ___/___/____ Wt: _____lbs

Life Threatening Food Allergy / Special Dietary Needs / Disability: _____

1. Omit these foods: ___ milk/dairy ___ peanuts/tree nuts ___ eggs ___ fish/shellfish ___ wheat ___ soy
   Other _____

2. Can the student consume foods where the allergen is an ingredient in the food product? ___ yes ___ no
   (*Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed, fluid milk is omitted but milk as an ingredient is allowed*) Explain_____

3. Major life activity affected by the life threatening food allergy or disability (check all that apply):
   ___eating ___caring for one's self ___ performing manual tasks ___ walking ___ seeing ___ hearing
   ___speaking ___breathing ___ learning

4. Foods to Substitute or Modify (A l*ist of substitutions is required. A marked menu from parent/guardian signed by medical authority may be required.)* _____

Information regarding Northside ISD nutritional programs may be found on the Child Nutrition website http://childnutrition.nisd.net. Information provided by the district on its website or by school cafeteria managers/staff is not intended as a substitute for advice from your physician or other healthcare professional. Parents are welcome to review ingredient labels and/or recipes and may do so by contacting the Director of Child Nutrition Services at 210-397-4512. It is the policy of Northside ISD not to discriminate on the basis of age, race, religion, color, national origin, sex or disability in its programs, services or activities.

Medications/Doses
Epinephrine (brand and dose): _____
Antihistamine (brand and dose): _____
Is the student asthmatic? ___yes ___ no Bronchodilator (brand and dose): _____

Treatment Plan: Physician to check appropriate medication(s)

Food allergen ingested – no symptoms	___ Epinephrine ___ Antihistamine
Respiratory – wheezing, shortness of breath, coughing	___ Epinephrine ___ Antihistamine
Cardiovascular –low blood pressure, weak pulse, pallor/blue	___ Epinephrine ___ Antihistamine
GI – nausea, vomiting, diarrhea, cramping	___ Epinephrine ___ Antihistamine
Skin – hives, itching, rash, swelling of face/extremities	___ Epinephrine ___ Antihistamine
Mouth – swelling lips/tongue, itching, tingling	___ Epinephrine ___ Antihistamine
Throat – tightening, hoarseness, coughing	___ Epinephrine ___ Antihistamine
Other - _____	___ Epinephrine ___ Antihistamine
Symptom Worsening - _____	___ Epinephrine ___ Antihistamine

Parent consents for nurse follow up with physician? ___ yes ___ no _____ _____
Parent Signature Date

Physician recommendations for medication self-administration: (Initial one)
____ The student above has been instructed by me in the proper way to use his/her medication(s). It is my professional opinion that he/she be allowed to carry and self –administer the above medications while on school property or at school related events.
____ The student above in my professional opinion should NOT be allowed to carry and self-administer any of the above medication(s) while on school property or at school related events.

_____ _____
Physician Signature / Phone # **Date**

3300-11b
3 years

STU 206 08-11 R

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