Fort Worth INDEPENDENT SCHOOL DISTRICT

Fort Worth ISD Child Nutrition Services Dietary / Allergy Request Form

1559466938

Return completed form to the school nurse

1. Parent/Guardian: complete Section A. Sign and date form (required for processing)
2. Medical Authority: complete Section B. Print, sign and date form (required for processing)
3. Return completed form to the school nurse
4. Dietitians will review and process dietary requests in the order in which they are received
5. Incomplete form will be returned to the school nurse for parent/guardian completion

- Nutrition, carbohydrate content, and allergen information is available via MealViewer to help you plan your child's meals in a way that fits with your dietary and religious preferences, no dietary request form is needed. MealViewer can be accessed here: https://schools.mealviewer.com/district/FortWorthISD OR users can download the MealViewer To Go App available for Apple and Android devices.

SECTION A. To be Completed by Parent/Guardian

Student ID Number | **Student's Name (Last, First)** | **Date of Birth**

Request Type ☐ New ☐ Change/Modify ☐ Discontinue

Which meals provided by the School Cafeteria will the student eat? ☐ Breakfast ☐ Lunch ☐ NONE

Does the student have an identified disability? (IEP or 504 Plan)? ☐ IEP ☐ 504 ☐ No

Parent/Guardian Email Address (CLEARLY PRINT)

Parent Requests that are not due to a medical disability. Please Note: Nutrition Services may attempt to accommodate cultural/personal preferences but are NOT required by law to do so. These accommodations depend on product availability on the daily serving line. ☐ **Vegan** ☐ **Vegetarian** ☐ **No Pork** ☐ **No Beef** ☐ **Other**

Section B will not be required for requests not due to a medical disability.

This form must be completed at the start of each school year and any time there is a change or discontinuation of dietary needs during the school year. Annual completion of this form by the student's medical authority ensures that current nutritional needs are being communicated.
I give Fort Worth ISD Child Nutrition Services permission to speak with the medical authority to discuss dietary needs as ordered.

X
PARENT/GUARDIAN SIGNATURE **Date** **Phone number of Parent/Guardian**

SECTION B. To be Completed by Physician/Medical Authority

TEXTURE MODIFICATION:

☐ Year Round ☐ Temporary: Start: ____ Stop: ____

Special Utensils required: ____

Specific Nutritional Needs: (carbs, calories, etc.): ____

Liquids: ☐ Thin (Regular liquids) ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

Solids: ☐ Regular ☐ Soft & Bite-Sized ☐ Minced & Moist ☐ Pureed

ALLERGIES (Select all that apply):

EGG
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ Baked goods with any egg listed as an ingredient

DAIRY
- ☐ All food/beverages with milk listed as an ingredient including baked goods
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Yogurt
- ☐ Fluid Milk (Substitution: ☐ Lactose-free milk ☐ Water ☐ Soy)

FISH OR SHELLFISH
- ☐ Fish
- ☐ Shellfish

WHEAT / GLUTEN
- ☐ Recipes with wheat listed as an ingredient
- ☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn products listed as an ingredient

NUTS
- ☐ Peanuts
- ☐ Tree Nuts specify: ____

SOY
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Menu items with any soy listed as an ingredient

OTHER ____

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Name of Medical Authority: ____ (PLEASE PRINT) ☐ MD ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP

Prescribing Physician/Medical Authority Signature: ____ (SIGNATURE) ____ (DATE)

Phone Number: ____

School Nurse/Office Personnel USE ONLY

Manager's Name: ____ Manager's Email: ____ Phone Number: ____ School Name & Number: ____

School RN Name: ____ School RN Phone Number: ____ School RN Email: ____

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Specialized Health Care Procedure Authorization Form
Physician's Request for School Health Services

The Fort Worth Independent School District Health Services Department Personnel or other designated employees will provide specialized health care procedures when they are required for students to remain in school. The school nurse will coordinate all procedures in the building(s). The Specialized Health Care Procedure Authorization Form must be completed each school year for all specialized health care procedures provided at school. It must include the physician/licensed prescriber's signature and parent/guardians signature.

School Name: _____ **School Year** _____

Name of Student: _____ **DOB** _____

Based on my evaluation as a physician/licensed prescriber, the above named student requires the following health care service(s) in order to be educated at school:

Name of Procedure(s) (Please include name and dosage of medication if appropriate):

_____

_____

_____

Effective from: _____ through: _____

Physical condition for which procedure is to be performed: _____

_____

Times scheduled and indication for procedure: _____

_____

Physician's Directions: _____

_____

Precautions, possible reactions: _____

_____

Circumstances in which the physician should be contacted: _____

_____

The following person(s) as designated by the principal, may be trained by the school nurse to perform the above listed procedures: Health Assistant, Teacher, Aide, Secretary/Clerk, and/or other.

Physician's Name (Print) _____ Signature: _____

Date: _____ Address: _____

Telephone: _____ Fax: _____

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Parent's Request for School Health Services

I, the undersigned, parent/guardian of _____

D.O.B. _____ request that the following specialized health care(s) be

be administered to my child during school hours:

_____
Name of Procedure(s)

I understand that I am responsible for providing all medications and equipment needed to perform the service.

I release those persons designated by my physician/licensed prescriber to perform the service from all liability.

I understand that whenever possible the specialized health care service should be provided before or after school hours.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed procedure(s) or medical condition(s) being treated.

I will notify the school immediately if the health status of my child changes, if I change physicians/licensed prescribers, or if the procedure is changed or cancelled.

_____
Signature of Parent/Guardian

Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Note: This request must be resubmitted every school year. Medical equipment and supplies provided by the family for Specialized Health Care Procedures will be sent home for thorough cleaning and/or to be replaced as needed.

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Medication Administration Request Form

Student: _____ Date of Birth: _____

School Name: _____ Grade: _____

Physician/Licensed Prescriber to complete: Medication

Allergies: _____

MEDICATION(S)	STRENGTH	DOSAGE	ROUTE	TIME(S)	COMMENTS

Physician/Licensed Prescriber's Signature: _____ Date: _____

Physician/Licensed Prescriber's Printed Name: _____

Phone: _____ Fax: _____

Parent/Guardian to complete:
I hereby represent and attest that I am the parent or legal guardian of the above-named student. I hereby request that the medication(s) specified above be administered to the above named student beginning on the following date: _____ and ending on the following date: _____
As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. On behalf of the above named student, myself, and our personal representatives, family members, heirs, assigns, and successors. I also agree and do hereby waive and release all claims for loss, damage, or injury against the Fort Worth Independent School District and any teacher, employee, volunteer, agent, or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Printed Name: _____

Telephone: Home _____ Cell _____ Work _____

CONFIDENTIAL PROTECTED HEALTH INFORMATION: This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal and Texas law and District policy prohibit, and require utilization of appropriate safeguards against, wrongful use, access or disclosure of protected health information, other than as allowed by applicable Federal and state law and District Policy. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal and/or State law, discipline by the District, or both.

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Self- Administration of Prescribed Asthma or Anaphylaxis Medicine by Student

This form is to be completed by the parent and physician/licensed health care provider of students who are to keep prescribed asthma or anaphylaxis medication on their person and self- administer it as prescribed.

School Name: _____ *School Year:* _____

Parent Request

We, the undersigned parents of _____ *request that our child be allowed to keep the prescribed asthma or anaphylaxis medication on his/her person at all times and self- administer it as requested by the physician.*

We understand that it is the student's sole responsibility to keep the prescription medication on his/her person. If they are misplaced or used by other students, this privilege will be revoked.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____ _____
Signature of Parent(s) *Date*

Physician Request

You are hereby authorized to allow _____ *to carry the prescription medicine on his/her person at all times.*

_____ _____
Name of Medication *Dosage and Time of Administration*

Please check all that is applicable.
_____ *Student is knowledgeable about the medication and how to administer it.*
_____ *Student has the skills to safely possess and use the prescribed medication.*
_____ *Student may self-administer the medication.*

All authorizations expire at the end of the school year.

_____ _____
Signature of Physician/Licensed Health Care Provider *Telephone Number*

_____ _____
Printed Name of Physician/Licensed Health Care Provider *Date*

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

_____ _____
Signature of School Nurse *Date*

R6/13/07

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

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): _____

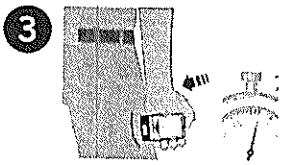
_____

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

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

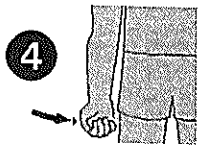
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



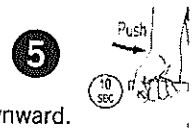
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

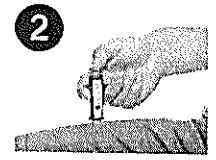


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____