Campus_____ Attach Photo Here

Northside Independent School District
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: ☐ **No Wheat** ☐ **No Peanut** ☐ **No Tree Nut** ☐ **No Fish** ☐ **No Shellfish**

☐**Dairy/Milk Allergy:** ☐ No Fluid Dairy Milk (Soy Milk offered) ☐ No Yogurt ☐ No Cheese ☐ No dairy/milk in baked goods
☐**Lactose Intolerance** (Lactose free milk offered)

☐**Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites ☐ No eggs in baked goods

☐**Soy allergy:** ☐ No Soy Protein/Soy Milk ☐ No Soy in Products (to include soy oil and soy lecithin)

☐Omit food "processed in a facility" with above checked ingredients or specific ingredient _____

☐Other (Please list): _____

2. 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

3. 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://nisd.net/child-nutrition. 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**