Tyrone Area School District

SECTION: PUPILS

TITLE: DIETARY RESTRICTIONS

ADOPTED: JULY 19, 2005

REVISED:

	254. DIETARY RESTRICTIONS
1. Purpose	The Board is committed to providing a safe and healthy environment for all students and staff.
2. Authority	The Board authorizes the Superintendent to prepare detailed administrative procedures to ensure the safety and well-being of students and staff. The purpose of this policy shall be two-fold: to safeguard the health and well-being of all students, and to address special medical and dietary needs of identified students.
3. Definitions	Dietary restrictions – any modification to a student's diet as a result of a medically diagnosed condition. Medical conditions may include, but are not limited to, food allergy, food intolerance, diabetes, PKU, etc.
4. Guidelines	The following procedures must be initiated by parents/guardians requesting dietary accommodations: • Parents/Guardians must provide a request for dietary accommodations on an annual basis using the district form. • A Food Allergy Action Plan will be completed by the physician, if needed. • After completion of the district form, a meeting will be scheduled with the parent/guardian and appropriate school personnel, at which time, a Service Agreement may be written. • The Service Agreement Team will determine the appropriate dietary accommodations to be implemented.
5. Delegation	The Superintendent designates the Elementary and Secondary Local Education Agency Representative for Section 504 Service Agreements. The Local Education Agency Representative shall coordinate all services with the school nurse, nutrition coordinator, teacher and parents/guardians. REFERENCE: American With Disabilities Act - Section 504, Chapter 15

FOOD ALLERGY ACTION PLAN

Place Child's Picture Here

Student's Name _____ D.O.B. _____ Teacher _____

ALLERGY TO _____

Asthmatic: ☐ Yes* (*Higher rish for severe action) ☐ No

STEP 1: TREATMENT

Symptoms		Give Checked Medication	
•	If a food allergen has been ingested, but no symptoms	o EpiPen	o Antihistamine
•	Mouth Itching, tingling, or swelling of lips, tongue, mouth	o EpiPen	o Antihistamine
•	Skin Hives, itchy rash swelling of the face or extremities	o EpiPen	o Antihistamine
•	Gut Nausea, abdominal cramps, vomiting, diarrhea	o EpiPen	o Antihistamine
•	Throat † Tightening of throat, hoarseness, hacking cough	o EpiPen	o Antihistamine
•	Lung † Shortness of breath, repetitive coughing, wheezing	o EpiPen	o Antihistamine
•	Heart † Thready pulse, low blood pressure, fainting, pale, blueness	o EpiPen	o Antihistamine
•	Other † _____	o EpiPen	o Antihistamine
•	If reaction is progressing (several of the above areas affected), give ……	o EpiPen	o Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening

DOSAGE

Epinephrine: inject intramuscularly (circle one): EpiPen EpiPen Jr.

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

STEP 2: EMERGENCY CALLS

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

1. Call 911 (or Rescue Squad: _____ _____ State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr _____ at _____

3. Emergency contacts:

Name/Relationship	**Phone Number(s)**	**Phone Number(s)**
a.	1)	2)
b.	1)	2)
c.	1)	2)

Parent/Guardian Signature _____ Date: _____

Doctor's Signature (Required) _____ Date: _____

Medical Statement For Children With Special Needs
In Child Nutrition Programs

Student's Name: _____ Age: _____

School Name: _____ Grade Level: _____ Classroom: _____

Does the student have a disability that requires the student to have a special diet or feeding equipment/utensils? ☐ No ☐ Yes. If Yes, describe the disability and the major life activity affected by the disability, complete this form, and have it signed by the student's physician. Return it to the school when completed.
Describe the disability/diagnosis: _____

If the student is NOT disabled, does he/she follow a special dietary modification or require assistance in eating? ☐ No ☐ Yes
Describe the dietary modification or assistance required: _____

Diet Prescription:

List Food Allergies/Intolerances:

List Allowable Food Substitutions:

Indicate any texture modifications and which foods need to be modified:
☐ Chopped/Cut up: _____
☐ Ground: _____
☐ Pureed: _____

☐ Liquid Modifications: Honey Nectar Other (specify)

List special equipment/utensils needed: _____

Additional comments about the student's eating patterns or dietary modifications:

Parent's Signature: _____ Date: _____

Physician's or Medical Authority's Signature: _____ Date: _____