



City of St. Charles R-6 School District 400 N. Sixth St., St. Charles, MO 63301

Allergy Procedure Sheet

Building: _____ Phone: _____ Fax: _____
Contact: _____ Date: _____

To the parents/guardian of: _____

Our health records show you indicated he/she has

- a food allergy to _____
- a latex allergy
- a bee or insect allergy

To comply with the district's Allergy Prevention and Response Policy JHCF as mandated by state statute Section 167.208 RSMo, an allergy emergency action plan **must** be on file for each student identified with a potentially life threatening allergy. As of this date, we have not received a physician order to provide a special meal to avoid a potential reaction or to treat him/her should a reaction occur at school. Please indicate below the action to be taken:

- _____ Due to this allergy my child requires a special meal. **Complete the directions for #1.**
- _____ My child has this allergy and must take Benadryl and/or use an EpiPEN immediately. **Complete the directions for #2, #3, #4 and/or 5.**
- _____ My child has this allergy, but is self controlled by avoiding the allergen. I will send in Benadryl. **Complete the directions for #2 and #3. **If no documentation will be provided by a physician, an allergy cannot be accommodated by the food services department.**
- _____ My child has this allergy, but is self controlled by avoiding the allergen. There is no need for an Allergy Emergency Action Plan at school. I will complete the appropriate allergy assessment form. **Complete the directions for #2. **If no documentation will be provided by a physician, an allergy cannot be accommodated by the food services department.**
- _____ This allergy has not been verified by a physician. I will complete the appropriate allergy assessment form. **Complete the directions for #2. **If no documentation will be provided by a physician, an allergy cannot be accommodated by the food services department.**

- #1 MEDICAL STATEMENT FOR STUDENT REQUIRING SPECIAL MEALS – FOR A SPECIAL DIET AT SCHOOL** must be completed, signed by the physician and parent, and returned to the clinic.
- #2 FOOD, INSECT OR BEE, or LATEX ALLERGY ASSESSMENT FORM** must be completed by the parent and returned to the clinic.
- #3 NON-PRESCRIPTION MEDICATION FORM – TO GIVE BENADRYL AT SCHOOL** must be completed, signed by the parent, and returned to the clinic along with the Benadryl product.
- #4 PRESCRIPTION MEDICATION FORM – TO HAVE AN EpiPEN AT SCHOOL** must be completed and signed by both the prescribing physician and the parent/guardian, and returned to the clinic with the EpiPEN.
- #5 TRANSPORTATION EMERGENCY ACTION PLAN** – must be completed and signed by the parent.

Please complete all necessary forms, sign this cover letter and return all forms to the clinic the next school day. If you need forms faxed to your child's doctor, I'd be happy to assist you. Based upon the severity of your child's allergy, an allergy emergency action plan may need to be developed by the clinic personnel.

Thank You,

School Nurse

Parent Signature

Date