Dear Parent(s)/Guardian(s):

It is listed in our records that your child has an allergy. In preparation for the 2020-2021 school year, we suggest having the included Individual Health Care Plan (IHCP) reviewed and signed by yourself and your child’s physician during the summer.

The Individual Health Care Plan (IHCP) must be submitted each school year, even if there has been no change to your child’s allergy action plan. If your child no longer suffers from an allergy and you are still receiving this letter, please ensure that you have a doctor’s note submitted to the nursing department in order to clear your child from the allergy list within the school’s system.

Please ensure that you fill out the whole IHCP and that the action plan is specifically filled out by your child’s primary care physician.

At your earliest convenience, please call the nursing department for your child’s grade to set up an appointment to discuss your child’s Individualized Health Care Plan and bring in the items listed on the following page. Thank you in advance for your response to this important matter.

Sincerely,

Mystic Valley Regional Charter School Nursing Staff

Kindergarten x2007          Main Building x7010          Annex Building x3118          High School x4108
576 Eastern Ave       Grades 4-7                             Grades 1, 2, 3 & 8                        Grades 9-12
770 Salem St                        30 Laurel St                               306 Highland Ave
Mystic Valley Regional Charter School
770 Salem Street • Malden, MA 02148 • Telephone 781-388-0222 • Facsimile 781-338-2122

Food Allergy Action Plan

Student’s Name: ___________________________ D.O.B: ___________ Teacher: ___________________________

** Place Child’s Picture Here **

**ALLERGY TO:**

Asthmatic: Yes [ ] No [ ] *Higher risk for severe reaction*

**STEP 1: TREATMENT**

<table>
<thead>
<tr>
<th>Symptoms:</th>
<th>Give Checked Medication***:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ If a food allergen has been ingested, but no symptoms:</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Mouth: Itching, tingling, or swelling of lips, tongue, mouth</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Skin: Hives, itchy rash, swelling of the face or extremities</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Gut: Nausea, abdominal cramps, vomiting, diarrhea</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Throat†: Tightening of throat, hoarseness, hacking cough</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Lungs†: Shortness of breath, repetitive coughing, wheezing</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Heart†: Weak or thready pulse, low blood pressure, fainting, pale, blueness</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ Other†: __________________________________________</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>▪ If reaction is progressing (several of the above areas affected), give:</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
</tbody>
</table>

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

**DOSAGE**

Epinephrine: inject intramuscularly (circle one) EpiPen®  EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give__________________________ medication/dose/route

Other: give__________________________ medication/dose/route

**IMPORTANT:** Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

**STEP 2: EMERGENCY CALLS**

1. Call 911 (or Rescue Squad: ____________). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ____________________________ Phone Number: ____________________________
3. Parent: ____________________________ Phone Number(s): ____________________________
4. Emergency contacts: 
   Name/Relationship: ____________________________ Phone Number(s): ____________________________
   a. ____________________________ 1.) ____________________________ 2.) ____________________________
   b. ____________________________ 1.) ____________________________ 2.) ____________________________

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

Parent/Guardian’s Signature: ____________________________ Date: ____________________________

Doctor’s Signature: ____________________________ Date: ____________________________
Mystic Valley Regional Charter School
770 Salem Street • Malden, MA 02148 • Telephone 781-388-0222 • Facsimile 781-338-2122

TRAINED STAFF MEMBERS

1. ___________________________________________ Room ________
2. ___________________________________________ Room ________
3. ___________________________________________ Room ________

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.
- Hold black tip near outer thigh (always apply to thigh).
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- Remove caps labeled “1” and “2.”
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don’t improve after 10 minutes, administer second dose:

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
- Slide yellow collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.**
Checklist for Allergy Action Plan and Individual Health Care Plan

Please ensure that you submit your student/child’s care plan with the following items prior to having an appointment with your school nurse for review.

1. Updated parent/guardian consent for medical administration ______

2. An Allergy Action Plan with: a complete list of each allergy, a doctor’s order/letter outlining the step by step instructions the School is to follow, and the medication(s) to be given (including dosage, frequency, route, and which symptoms require which medication).

3. Updated parent/guardian phone numbers ______

4. Updated emergency contacts and phone numbers ______

5. Physician name, phone, and address ______

6. Proffered hospital name, phone, and address ______

7. 2 EpiPens (1 for student and 1 for nurse) ______

8. Any other medication that may need to be given (i.e. Benadryl) for an allergic reaction ______

9. 2 Pictures of your child (wallet-size or smaller) ______

10. A brief medical history including current, up to date medication list ______

11. Authorization Release or Request Form ______

12. Consent for Medication Administration Form ______

13. Copy of most recent yearly physical exam ______

Please call your child’s School Nurse if you have any questions or concerns.
2020-2021 (IHCP) Individualized Health Care Plan For Allergic Reaction(s)

Student’s Information:

Name: ______________________________________________________ DOB: _______________
Allergies: ______________________________________________________________________________
Grade: ________ Teacher: ______________________________________________________________

Parent(s)/Guardian(s) Contact Information:

Name: ______________________________________ Relationship: ____________________________
Cell: ____________________________________ Work: __________________________________

Name: ______________________________________ Relationship: ____________________________
Cell: ____________________________________ Work: __________________________________

Emergency Contact Information (to be used if parents are unavailable):

Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________
Name: ____________________________ Phone: ____________________________

Physician/Hospital Information:

Physician: ____________________________ Phone: ____________________________
Address: ______________________________________________________________________________

Hospital: ____________________________ Phone: ____________________________
Address: ______________________________________________________________________________
Please write a brief note about the student’s allergy and/or the last encounter with the allergen.

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
AUTHORIZATION FOR RELEASE OR REQUEST 
OF CONFIDENTIAL INFORMATION

Name: _____________________________________________________     DOB: __________________

I give my permission to the Mystic Valley Regional Charter School to RELEASE the following information
TO the Doctor, Agency, or Institution listed below:

Psychiatric/Psychological   Educational   Speech/Language   IEP
Career Vocational Assessments Social History Social History 504
Student Health Records Other _____________________________________

I give my permission to the Mystic Valley Regional Charter School to OBTAIN the following information
FROM the Doctor, Agency or Institution listed below:

Psychiatric/Psychological   Educational   Speech/Language   IEP
Career Vocational Assessments Social History Social History 504
Student Health Records Other _____________________________________

Name of Doctor/Agency/Institution: __________________________________________________________

Purpose/Reason: ___________________________________________     Phone: ____________________
Address: ________________________________________________________________________________
_________________________________________________________________  _______________

_________________________________________________________  _______________
Signature and Relationship to Student           Date

Please return this form to the address above. These records are subject to the confidentiality rules
of the Commonwealth of Massachusetts under the provisions of Section 99.30 of the
FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT.
PARENT/GUARDIAN AUTHORIZATION FOR SPECIFIC HEALTH SERVICES

We/I, the undersigned who are/am the parent(s)/guardian(s) of:

X_______________________________________________________ Name and DOB

Request and approve the attached Individualized Health Care Plan (IHCP).

____I understand that a qualified, designated person or persons will be performing health care services.

____I will notify the school immediately if there are any changes in health status changes, physicians, or anything related to this IHCP.

____I agree to provide any medical equipment, supplies, medication, supplements, etc. noted in this plan.

X_______________________________________________________ Parent/Guardian Signature               Date

X_______________________________________________________ Nurse’s Signature               Date
PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Name: ____________________________________ Grade: _____ Teacher: ___________________

Allergies: _______________________________________________________________________

I give permission for the school nurse to give the following medications* for the duration of the 2020-2021 school year:

Name: ____________________________________  Dose: _________________  Time: ________
Name: ____________________________________  Dose: _________________  Time: ________
Name: ____________________________________  Dose: _________________  Time: ________
Name: ____________________________________  Dose: _________________  Time: ________
Name: ____________________________________  Dose: _________________  Time: ________

_____________________________  _______________
Signature and Relationship to Student           Date

PLEASE NOTE: Parent(s)/Guardian(s) need to bring in ALL medication to the school nurse. It cannot be sent to school with your student. The school does not provide any medications.

*For the purpose of administering emergency medication to an individual child, specifically administration of epinephrine by injection pursuant to 210.004 (B) (4), the school nurse may identify individual school personnel or additional categories. Said school personnel shall be listed on the medication administration plan and receive training in the administration of emergency medication to a specific child.
Goal: The goal is to keep this student safe by avoiding products which obviously contain or list the allergen(s) in their ingredients. Treat any symptom or anaphylaxis with and use emergency procedure guidelines.

Responsibilities:

Parent(s)/Guardian(s):

In order to help identify the student’s allergy and the degree of the allergy, parents will provide the School Nurse with the following:

1. Provide documentation (written protocol, emergency treatment plan, and written orders) from a licensed provider regarding each allergy, as well as one onset form to administer proper medication and one to share relevant information with school staff as deemed necessary by the School Nurse. Note: permission is only effective for the school year in which the prescription/protocol is granted and will need to be renewed each subsequent school year.
2. Consent form for School Nurse to communicate with the student’s designated licensed provider (regarding written allergy protocol, emergency treatment plan, and written orders).
3. Provide 2 Photos, 2 EpiPens, (one for the School Nurse and one for the classroom), and Diphenhydramine/Benadryl (either a bottle of liquid or dissolvable tabs). Medications must be replaced if they expire during the school year and it is the parent’s responsibility to ensure the medications are always valid and unexpired.
4. Provide a medical alert bracelet (if applicable). Parent(s)/Guardian(s) are responsible for educating the student with the importance of always wearing his/her medical alert bracelet, which is not to be removed under any circumstances.
5. Parent will provide safe snacks for the student for special events where outside food is provided.
6. Parent will send in a safe snack and drink every day that the student participates in the after-school/weekend MCAS remediation if the snack provided has been deemed unsafe for your child due to his/her allergies.

School:

1. Teachers and staff will adhere to and enforce the school policy of having ONLY the School Nurse check and approve all food provided by MVRCS for students to consume, including parties, celebrations, field trips, classroom rewards and any other school activity involving food during the school day.
2. Teachers and staff will be trained in how to recognize an anaphylactic reaction and how to respond. In the event of a suspected/known ingestion of, or contact with an allergen one staff member will bring the student to the School Nurse (if asymptomatic). If symptomatic, one teacher will administer the EpiPen and stay with the student at all times, while another student retrieves the School Nurse who will decide the course of action and if calling 911 is necessary. Parents will ALWAYS be notified immediately.
3. Teachers will receive a copy of Individualized Health Care Plan (IHCP) and Allergy Action Plan (AAP) and will leave information/location of medication in an accessible place for substitutes and specialty staff. The EpiPen will not be kept in any storage that is locked at any time that this child is on school grounds for a school activity.
4. School will ensure that this student has a parent or an EpiPen trained staff member for field trips.
5. Teachers and staff must notify the School nurse when planning to provide any food for the students. This food
can only be served to students with allergies if approved by the School Nurse with no exception.

6. Teachers will enforce the school’s no food trading policy.
7. Teachers will keep alternate safe snacks, provided by the parents, in a safe place in the classroom so students can feel included when outside food is being served to other students.
8. The EpiPen will travel with the student at all times during school hours, via the designee chosen by the teacher.

Student:

1. Will be aware, on an age appropriate level, of the details of his/her allergy (causes, symptoms, avoidance, and rules) and reactions.
2. Notify an adult immediately of any allergic symptom or if ingestion of allergen is suspected.
3. If applicable, will wear Medic Alert bracelet daily and not permit anyone to remove it under any circumstances.
4. Will not trade or share food for safety reasons.

School Nurse:

1. Will gather all proper documentation from family.
2. Meet with the parents and staff annually and as needed to update IHCP and AAP.
3. Provide IHCP and AAP to classroom staff and specialty staff.
4. The nurse will train all teachers and specialty staff in the use of EpiPen use and will maintain a list of trained personal. Training will also include what the allergy is and what symptoms to look for in an anaphylactic reaction.
5. The nurse will provide 6-month refresher instruction on EpiPen use and will have periodic drills on emergency procedures.
6. Will check all MVRCS provided food prior to allowing student to consume (or come in contact with) it during classroom parties, celebrations, field trips, classroom rewards, and any other activities involving school supplied food.

**DOCUMENTATION OF PARTICIPATION**

We, the undersigned, have participated in the development of and hereby accept the above Individual Health Care Plan (IHCP) and Allergy Action Plan (AAP):

X ______________________________________________________________________ Administrator/Designee

X ______________________________________________________________________ School Nurse

X ______________________________________________________________________ Parent/Guardian