Pottsboro Independent School District

Food Allergy Management Plan (FAMP)

School Year 2025–2026

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1. Purpose and Authority

The Pottsboro Independent School District (PISD) Food Allergy Management Plan (FAMP) is designed to reduce the risk of exposure to food allergens, provide appropriate care for students with food allergies, and ensure a rapid and effective response in the event of an allergic reaction. This plan is adopted in accordance with the Texas Education Code §38.0151 and the Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis issued by the Texas Department of State Health Services (DSHS).

This plan is reviewed annually and applies to all students, staff, substitutes, volunteers, and school-sponsored activities.

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2. Definitions

Food Intolerance
An unpleasant reaction to food that does not involve an immune system response and is not life-threatening.

Allergic Reaction
An immune-mediated reaction to a food protein.

Severe Food Allergy
An allergy that may result in an anaphylactic reaction.

Anaphylaxis / Anaphylactic Reaction
A serious, rapid-onset allergic reaction that may result in death if not treated promptly.

Food Allergy Management Plan (FAMP)
The district-wide plan outlining general and specific procedures to reduce risk and manage food allergies.

Food Allergy Action Plan (FAAP)
A personalized plan completed by a healthcare provider detailing prevention strategies and response actions.

Emergency Action Plan (EAP)
A healthcare-provider-developed plan specifying emergency procedures for allergic reactions.

Individualized Health-Care Plan (IHP)
A plan written by a school nurse, based on medical orders, describing accommodations and nursing services.

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3. District Food Allergy Coordinator

The Superintendent has designated the following staff member as the District Food Allergy Coordinator:

> **Name:** Whitney Davis
> **Title:** Director of Federal & Campus Programs
> **Address:** 1401 Katy Lane, Pottsboro, TX 75076
> **Phone:** (903) 771-0083 ext. 5100

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4. Roles and Responsibilities

The District Food Allergy Coordinator shall: 1. Oversee the development, implementation, and annual review of the FAMP. 2. Disseminate district policies, procedures, and forms related to food allergies. 3. Coordinate development and use of approved forms (FAAP, EAP, IHP, incident reports). 4. Ensure food allergy information is requested at enrollment and maintained in student records. 5. Obtain and provide ongoing training related to food allergy management. 6. Ensure appropriate staff receive student-specific training as required. 7. Develop strategies to reduce exposure to allergens across district facilities and activities. 8. Coordinate procedures for student self-administration of prescribed allergy medications. 9. Maintain records and incident reports related to anaphylactic reactions. 10. Review student plans after any anaphylactic event.

5. District-Wide Food Allergy Management Procedures

Training

The District will provide: - Specialized training for staff responsible for implementing and monitoring the FAMP. - General food allergy awareness training for all employees, including: - Recognition of symptoms - Emergency response procedures - Strategies to reduce allergen exposure - Bullying prevention and response related to food allergies

Environmental Controls and Risk Reduction

General strategies include: - Limiting or eliminating food in classrooms when necessary. - Implementing cleaning and sanitation protocols, especially in high-risk areas. - Promoting handwashing with soap and water before and after meals. - Discouraging food sharing and trading. - Assigning trained staff in cafeterias and during school-sponsored activities. - Implementing risk-reduction strategies for classrooms, cafeterias, buses, field trips, extracurricular activities, and before/after-school programs.

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6. Identification of Students with Food Allergies

At enrollment and annually thereafter, parents/guardians are requested to disclose: - Whether the student has a food allergy or severe food allergy - The specific allergen(s) - The nature of the allergic reaction

This information is maintained in accordance with FERPA and district policy.

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7. Students at Risk for Anaphylaxis

When a student is identified as having a severe food allergy, the campus principal, counselor, or nurse will request documentation completed by a licensed healthcare provider, including: - Food Allergy Action Plan (FAAP) - Emergency Action Plan (EAP) - Medication authorization forms, if applicable - Statement Regarding Meal Substitutions or Modifications, if requested

Based on this documentation, the school nurse may develop an Individualized Health-Care Plan (IHP).

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8. Eligibility for Accommodations Under Federal Law

Students whose food allergies substantially limit a major life activity may qualify for accommodations under Section 504 of the Rehabilitation Act. A Section 504 committee will determine eligibility and develop a plan as appropriate.

FAAPs, EAPs, or IHPs alone do not constitute a Section 504 or IDEA service unless specifically included in a formal plan.

9. Notification, Communication, and Training

In compliance with FERPA, appropriate notification and training will be provided to relevant staff, substitutes, and volunteers regarding: - Allergen avoidance strategies - Recognition of symptoms - Emergency response procedures

10. Response to Anaphylactic Reactions

Following an anaphylactic reaction at school or a school-sponsored activity: - An incident report will be completed and submitted to the Superintendent or designee. - Emergency response actions will be reviewed. - Student care plans will be updated as needed. - Parents/guardians will replace used emergency medication. - If applicable, the Section 504 committee will reconvene.

11. Review and Continuous Improvement

- Individual student plans are reviewed periodically and after any anaphylactic reaction.
- The district FAMP is reviewed annually through the School Health Advisory Council (SHAC).

12. Student Health Plans for Other Medical Conditions

When required for school attendance, an IHP will be implemented and coordinated with any Section 504 plan.

13. Required Forms and Exhibits

- Letter Requesting Additional Documentation
- Statement Regarding Meal Substitutions or Modifications
- Licensed Prescriber Authorization
- Medication Authorization
- Anaphylaxis Incident Report Form

Dear Parent:

You have disclosed that your child has a food allergy. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Request for the Administration of Medication at School (requires MD signature)

2. Authorization for Anaphylaxis Medication (requires MD signature)

3. Statement Regarding Meal Substitutions or Modifications (requires MD signature)

4. Food Allergy Action Plan (requires MD signature)

Please have your physician or other licensed health-care provider complete these forms and return them to the nurse within 10 business days.

Sincerely,

School Nurse

A Note From the Nurse

To the parent/guardian of: _____

On the annual health history form that you completed at the beginning of the school year, you listed that your child suffers from food allergies. It is very important that your child's food allergies are properly managed at school to prevent a possible allergic reaction. In order to provide the best possible care for your child throughout the school year please answer the following questions. Remember, working together as a team is the best way to help keep your child safe.

Please remember that lactose intolerance IS NOT a food allergy. If your child suffers from lactose intolerance rather than an actual milk allergy, please note that on the form. It is very important that the nurse know which it is because an allergic reaction requires different treatment than intolerance.

What food is your child allergic to? _____

What type of reaction does your child have and how severe is the reaction?

_____

_____

_____

FOOD ALLERGY MEDICATION

*I recommend that all students with a food allergy keep an Epi-Pen in the nurse's clinic for emergency use. *

_____ Yes, my child will require medication at school in the event of an allergic reaction. If medication is needed at school, please complete the attached medication permission form. Return this questionnaire, the medication permission form and the medicine to your child's school.

_____ No, my child's allergic reaction is mild and he/she will not require any medication for it at school.

VERY IMPORTANT: Your child's teacher will be informed of his/her food allergy but it is very important that you speak with your child at home about not accepting that particular food if it is offered to them. In addition, the cafeteria will require a note from your child's doctor in order to substitute that food for another in the cafeteria.

*Please feel free to contact me with any questions/concerns. *

Attached to this letter are the following forms:

1. Request for Administration of Medication at School
2. Authorization for Anaphylaxis medication/Food Allergy Care Plan
3. Pottsboro ISD Medical Statement- Food Accommodation Form

These forms must be signed by you and the Dr. within 10 business days to remain on the food allergy list

PARENT SIGNATURE: _____

(this form must be signed by you and returned within 3 school days)

Pottsboro ISD Medical Statement

(To Provide Information for a School to Make an Appropriate Meal Accommodation)

This form may be (1) used by a licensed medical authority to provide a medical statement for a student's medical disability or a special dietary need that warrants a meal accommodation or (2) used to assist a licensed medical authority in creating the medical statement necessary for a meal accommodation. If this form is used as a medical statement, the form must be completed by the medical authority and signed by both the parent and the medical authority. The second page of this form provides additional information on the regulations related to school meal accommodations.

I. Provide the following information about the student.

Student Name: _____ Date: _____

Student Birthdate: _____ Student's Grade Level: _____

Does the student have a medical disability which affects one of the major life functions which necessitates a meal accommodation? ☐ Yes ☐ No

Does the student have a special dietary need or religious preference that will be helped by a meal accommodation? ☐ Yes ☐ No

II. How does this medical disability or special dietary need/religious preference impact the student's diet?

III. What meal accommodation(s) are appropriate to address the student's medical disability or special dietary needs? Please check the box before applicable meal accommodations and provide a detailed explanation for each checked accommodation in the box beside the description.

☐ Food items or ingredients not to be served.

Please keep in mind classroom parties; as well as if dairy/milk is listed this includes ALL foods containing this (example: candy and ice cream)

☐ Suggested substitutions for food items not served

☐ Other

IV. Provide the following signatures.

Parent Signature _____ Date _____

Medical Authority Signature _____

ONLY PARENT signature needed if dietary NEED is for religious purposes.

Information on Accommodations to School Meals for Students with a Medical Disability

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) must provide reasonable accommodations for students with medical disabilities.

The Code of Federal Regulations (7 CFR, Part 15b) defines a person with a disability as (1) having a physical or mental impairment that substantially limits one or more major life activities and (2) having a record or is regarded as having a physical or mental impairment.

For an NSLP or SBP site to provide a meal accommodation for a student with a medical disability, the parent or guardian must provide a medical statement signed by medical authority who is licensed by the State to write prescriptions. For this purpose, State is defined as the State of Texas. Any medical authority whose prescription is allowed to be filled by a pharmacy located in Texas under Texas law and regulation may provide a medical statement for a meal accommodation.

The medical statement must include the following information in order for the Pottsboro ISD to make the meal accommodation:

1. Statement explaining the student's medical disability which includes a description that is sufficient to allow the school to understand how this condition restricts the student's diet
2. Description of the accommodation to be made: food items or ingredients to be omitted, food items ingredients to be substituted, modified food texture, and/or other accommodation
   If the medical statement requires substitutions, the medical statement should include a list of food or beverage items that are appropriate substitutions. Also note, a school is not required to provide a name brand product if another product with the same specifications is available.

If the licensed medical authority does not provide a medical statement that includes the information listed above, the school cannot make a meal accommodation. Any previous meal accommodations submitted by the licensed medical authority will stand as submitted on the student until a change by the licensed medical authority has been to the school nurse.

When a school believes the medical statement is unclear or lacks sufficient detail, the school must request appropriate clarification so that a proper and safe meal can be provided. When clarification is provided, any changes to the medical statement must be provided in writing before the school implements the changes.

Licensed Prescriber Authorization

I am prescribing the following medication{s) for the student to be administered at school.

Daily

Name	Diagnosis	Route	Time(s)	Dose	Possible Side Effects

PRN

Name	Diagnosis	Route	Time(s)	Dose	Possible Side Effects

OTC

Name	Diagnosis	Route	Time(s)	Dose	Possible Side Effects

The above orders shall be effective throughout the current school year unless the orders are discontinued, changed or withdrawn in writing by the parent.

Licensed Prescribers signature: _____

Licensed Prescribers Printed Name: _____

Date: _____ phone #: _____

Parent Signature: _____

Medication Authorization

Student's Name: _____ Student ID #:_____

School: _____ Grade: _____ Date of Birth: _____

Allergies: _____

Parent Permission

- I request that authorized persons at my child's school assist my child in taking the prescription or over-the-counter medication(s) described below at the time indicated and as designated by his/her licensed prescriber.
- I request that my child be allowed to self-carry and self-administer medication. I shall hold harmless and indemnify PISD, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.

I, or a responsible adult, will be responsible for bringing the prescription or over-the-counter medications to school in a labeled container from the pharmacist or the manufacturer's container. I also understand that I am responsible for maintaining enough of the medication at the school. Failure to do this will result in an interruption of the licensed prescriber's order or discontinuation of the school's administration of the medication for my child. I understand that, if my child refuses to take the medication(s) the medication(s) will not be given, and the parent will be notified.

School personnel have permission to communicate with the licensed prescriber regarding use, side effects, response, and contraindications of the medication(s).

- I confirm that my child has previously taken this medication.
- My child has not previously taken this medication, but this is an emergency medication.

Signature of Parent/Legal Guardian: _____

Date:_____

Telephone #: _____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

