Celiac Care Plan

Dear Parents/Guardians,

This packet includes a Celiac Care Plan and Permission to Administer Medication form. These completed forms will assist The Classical Academy staff in knowing how to manage your student's condition should an emergency arise.

The Permission to Administer Medication form is your physician's order for the school to administer a medication. Academy District Twenty and The Classical Academy policies require the signature of a health care provider with prescriptive authority, as well as the parent/guardian signature, for all medications to be given at school. This includes prescription and over-the-counter medications such as cough drops, Tylenol etc. Each medication requires a separate Permission to Administer Medication form. The forms are available on our website at http://www.tcatitans.org. High School students may carry and self-administer their own medications with the exception of controlled substances, which must be kept in the health room with a completed medication form.

Please fill in the parent portion of the care plan and medication form prior to giving to your physician for completion and signature. Submit all forms to your student's health room before the start of school. **Please be sure to complete all pages of this packet as we will not accept incomplete Care Plans or medications without Permission to Administer Medication form.**

If you have questions, please feel free to contact the school nurse at your student's campus.

Sincerely,

Your Health Services Team

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ACADEMY DISTRICT 20/TCA
CELIAC INDIVIDUAL HEALTH CARE PLAN

Student's Name: ______________________________ **DOB:** _________________________
School: ______________________________________ **Grade:** _______________________
Parent/Guardian: ____
Home Phone: _________________________________
Dad's Cell Phone: ____________________________ **Dad's Work Phone:** ______________
Mom's Cell Phone: ____________________________ **Mom's Work:** __________________
Emergency Contact: ___________________________ **Phone:** _______________________
Physician: __________________________________ **Phone:** _______________________

<u>HISTORY:</u> ______________________ **has Celiac Disease, chronic autoimmune disease characterized by intestinal malabsorption of virtually all nutrients and precipitated by eating gluten-containing foods.** _________________ **diet also need to be casein, nut and legume free.**

PLAN OF CARE FOR CELIAC DISEASE:

Signs to watch for during school:

1. **Stomach ache, stomach cramps**
2. **Diarrhea**
3. **Abdominal pain**

The Classroom Teacher will:

1. **Confer with parent before any food is given in class, i.e. Birthday treats, holiday treats, etc**
2. **Confer with parent for food substitutes to use in food projects**
3. **Make sure** __________ **washes hands thoroughly after handling play-doh or any other substance he/she touches in class that could cause Celiac Disease to flare.**
4. **Immediately send** ________ **to the office if he/she has an accidental ingestion.**

The H ealth Room personnel will:

1. **Immediately call mother if** ______________ **arrives in the office.**
2. **Report any symptoms of abdominal pain, diarrhea, rash or unusual behavior to parent. Parent will determine if medications need to be given.**

The Parent will:

1. **Be responsible for immediate care of any problems**
2. **Keep school staff updated with any changes or care needed.**
3. **Provide medications with proper paperwork completed.**

___________________________________ ___________________________________
Parent's Signature **Date** **Nurse's Signature** **Date**

___________________________________ ___________________________________
Teacher's Signature **Date** **Physician Signature** **Date**

****This Health Plan and any Nurse delegation related to this plan are for use during normal operational school hours. After hours: call parent(s) and or 911 for all medical concerns/emergencies.**

List of foods that contain gluten.

Foods made from grains that contain harmful gluten include:

Wheat and any ingredient with wheat in its name (except buckwheat, which is gluten free)
Wheat flour (white, all purpose)
Rye
Barley
Oats (not considered safe due to cross contamination)
Malt and malt flavoring, syrup, and extract (usually made from barley)
Malt vinegar
Kamut
Triticale
Spelt
Durum
Farina
Einkorn
Semolina
Bulgar
Cake flour
Matzo
Matzah
Couscous
Wheat starch
Hydrolyzed vegetable protein
Most soy and teriyaki sauces
Licorice
Nuts (if they are flavored or roasted with a gluten-containing ingredient)
Modified food starch could be modified wheat starch. Most of the modified food starch used in the US is modified cornstarch.
Dextrin (which is rare, could be made from wheat)
Processed cheese may contain gluten
Real cheese coated with wheat to prevent caking
Seasoning and seasoning mixes need to be checked to be sure they are gluten free (plain spices are gluten free)
Flavorings could include gluten in the form of barley or malt. Wheat should be labeled now as an allergen.

Safe foods include foods made from grains that do not contain harmful gluten:
Corn, rice, amaranth, buchwheat (kasha), montina, millet, quinoa, tef, sorghum, and soy.
Plain fruits and vegetables
Plain meat, seafood, and eggs,
Plain nuts, beans, and legumes, and flours made from them
Potato/potato starch
Tapioca
Arrowroot.

Safe foods could be cross-contaminated by gluten in certain settings (i.e. buffet line, toasters, contaminated hands touching safe food…)

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Complete ONE form for EACH prescription or over-the-counter (OTC) medication

Student Name: ____ Date of Birth: ___ / ___ / ___

Medication Name, Form, and Strength (i.e., Children's Tylenol, liquid, 160mg/5ml): _______________

____

Reason for Medication: ____

Total Dose to Administer: _____________ Route: _____________ Time: _____________

If 'as needed' (PRN), indicate when dose can be repeated: ____________________________________

Special Instructions: ____

Possible Side Effects: ____

Start Date: ___ / ___ / ___ End Date: ___ / ___ / ___

Parent/guardian provided FDA-approved over-the-counter (OTC) medications may be administered at the school nurse's discretion without a signature from a prescribing provider below if given strictly within manufacturer's recommendations and instructions. All prescription medications must have a prescribing provider's signature.

Name of Health Care Provider: ____

Office Phone Number: _________________________ Fax Number: _________________________

Signature of Health Care Provider with prescriptive authority:

____ Date: ___/ ___/ ___

I understand that whenever possible, medication should be administered at home. I also understand that it is my responsibility to furnish the medication to school in the original pharmacy-labeled container or over-the-counter container identified with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian: ______________________________________ Date: ___ / ___ / ___

Contact phone numbers (home, cell, other): ____

Parent/Guardian Signature: ____

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