



Diet Modification Request Form

Modifications are required by The United States Department of Agriculture (USDA) to accommodate a disability. Under Section 504, the ADA, and the Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Major life activities" are broadly defined and include, but not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by state law to write medical prescriptions: In Iowa this includes only Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Physician's Assistants (PA), or Advanced Registered Nurse Practitioners (ARNP).

Please complete this form and return to your organization or provider: _____
(Name of home provider or organization)

Participant's Name: _____ Birth Date: _____ Grade: _____

Parent/Guardian's Name: _____

Does the participant have a disability? No Yes (identify)

1) Describe the medical need related to the diet order and "major life activity" (see above) affected.
Example: Allergy to peanuts affects ability to breathe

2) Explain what must be done to accommodate the medical need:

3) Food(s) or Formula to Omit:	Food(s) or Formula to Substitute:

Complete the back to provide additional details

Modified Texture: Not Applicable Chopped Ground Pureed

Modified Thickness of Liquids: Not Applicable Nectar Honey Spoon or Pudding Thick

Special Feeding Equipment: Not Applicable Equipment Needed: _____

(Example: large handled spoon, sippy cup, etc.)

Infants under one year of age must receive iron-fortified infant formula or breast milk unless a Diet Modification Request form is on file.

Licensed prescribing medical professional*: _____
Name (Print or Type) _____ Title _____

Signature of Medical Professional _____ Date _____

The program must make accommodations for disabilities. Accommodation is encouraged for other medical conditions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without direction from a medical professional. This site chooses to offer this nutritionally-equivalent product: _____.

Check here if you would like to request the milk substitute listed in place of fluid milk and list the reason for the request.

USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods:

Parent/Guardian signature: _____ Date: _____
(To document choices and for permission to share with appropriate staff as needed to make accommodations)

USDA is an equal opportunity employer and provider.

Participant's Name: _____

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services 11/2017

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – Do not serve the items checked below: <input type="checkbox"/> Fluid milk as a beverage or on cereal? 1/4 cup of fluid milk to be used on cereal? <u>yes</u> <u>no</u> <input type="checkbox"/> Yogurt <input type="checkbox"/> Milk based desserts such as ice cream and pudding <input type="checkbox"/> Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese <input type="checkbox"/> Cheese baked in products such as a casserole or on meat pizza <input type="checkbox"/> Cold cheese such as string cheese or sliced cheese on a sandwich <input type="checkbox"/> Milk in food products such as breads, mashed potatoes, cookies or graham crackers	SERVE THESE ITEMS INSTEAD:
Soy - Do not serve the items checked below: <input type="checkbox"/> Protein products extended with soy <input type="checkbox"/> Processed items cooked in soy oil <input type="checkbox"/> Food products with soy as one of the first three ingredients <input type="checkbox"/> Food products with soy listed as the fourth ingredient or further down the list	SERVE THESE ITEMS INSTEAD:
Egg - Do not serve the items checked below: <input type="checkbox"/> Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold <input type="checkbox"/> Eggs used in breading or coating of products <input type="checkbox"/> Baked products with eggs such as breads or desserts	SERVE THESE ITEMS INSTEAD:
Seafood – Do not serve the items checked below: <input type="checkbox"/> Fish (Cod, tuna, tilapia, haddock, salmon, etc.) <input type="checkbox"/> Shrimp <input type="checkbox"/> Other: _____	SERVE THESE ITEMS INSTEAD:
Peanuts – Do not serve the items checked below: <input type="checkbox"/> Peanuts, individually or as an ingredient <input type="checkbox"/> Foods containing peanut oil <input type="checkbox"/> Foods items identified as manufactured in a plant that also handles peanuts	SERVE THESE ITEMS INSTEAD:
Tree nuts – Do not serve the items checked below: <input type="checkbox"/> All nuts <input type="checkbox"/> Food items identified as manufactured in a plant that also handles nuts <input type="checkbox"/> Other: _____	SERVE THESE ITEMS INSTEAD:
Wheat – Do not serve the items checked below: <input type="checkbox"/> Foods containing wheat <input type="checkbox"/> Foods containing gluten <input type="checkbox"/> Oats <input type="checkbox"/> Other: _____	SERVE THESE ITEMS INSTEAD:

Name: _____ D.O.B.: _____

Allergic to: _____

 Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

 PLACE
PICTURE
HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____ THEREFORE:

 If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

 If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

Describe your child's past reactions:

 For any of the following **SEVERE** symptoms

LUNG

Shortness of breath, wheezing, repetitive cough


HEART

Pale or bluish skin, faintness, weak pulse, dizziness


THROAT

Tight or hoarse throat, trouble breathing or swallowing


MOUTH

Significant swelling of the tongue or lips


SKIN

Many hives over body, widespread redness


GUT

Repetitive vomiting, severe diarrhea


OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION

of symptoms from different body areas.

 For **MILD** Symptoms

NOSE

Itchy or runny nose, sneezing


MOUTH

Itchy mouth


SKIN

A few hives, mild itch


GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

1. INJECT EPHINEPHRINE IMMEDIATELY
2. CALL 911 Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

 Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

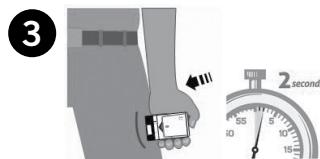
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____



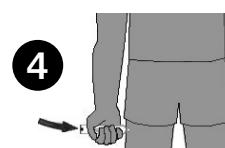
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



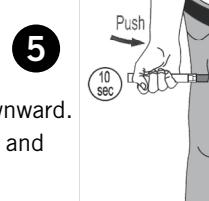
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENAClick®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Recognize and Respond to Anaphylaxis

For a suspected or active food allergy reaction

FOR ANY OF
THE FOLLOWING

SEVERE SYMPTOMS

-  **LUNG:** Short of breath, wheezing, repetitive cough
-  **HEART:** Pale, blue, faint, weak pulse, dizzy
-  **THROAT:** Tight, hoarse, trouble breathing/swallowing
-  **MOUTH:** Significant swelling of the tongue, lips
-  **SKIN:** Many hives over body, widespread redness
-  **GUT:** Repetitive vomiting, severe diarrhea
-  **OTHER:** Feeling something bad is about to happen, anxiety, confusion

OR MORE
THAN ONE

MILD SYMPTOM

-  **NOSE:** Itchy/runny nose, sneezing
-  **MOUTH:** Itchy mouth
-  **SKIN:** A few hives, mild itch
-  **GUT:** Mild nausea/discomfort

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INJECT EPINEPHRINE IMMEDIATELY

2

Call 911 Request ambulance with epinephrine.

Consider Additional Meds

(After epinephrine):

- » Antihistamine
- » Inhaler (bronchodilator) if asthma

Positioning

Lay the person flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.

Next Steps

- » If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- » Transport to and remain in ER for at least 4 hours because symptoms may return.

Do not depend on antihistamines. When in doubt, give epinephrine and call 911.



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How a Child Might Describe a Reaction

Children have unique ways of describing their experiences and perceptions, and allergic reactions are no exception. Precious time is lost when adults do not immediately recognize that a reaction is occurring or don't understand what a child is telling them.

Some children, especially very young ones, put their hands in their mouths or pull or scratch at their tongues in response to a reaction. Also, children's voices may change (e.g., become hoarse or squeaky), and they may slur their words. The following are examples of the words a child might use to describe a reaction:

- "This food is too spicy."
- "My tongue is hot (or burning)."
- "It feels like something's poking my tongue."
- "My tongue (or mouth) is tingling (or burning)."
- "My tongue (or mouth) itches."
- "It (my tongue) feels like there is hair on it."
- "My mouth feels funny."
- "There's a frog in my throat."
- "There's something stuck in my throat."
- "My tongue feels full (or heavy)."
- "My lips feel tight."
- "It feels like there are bugs in there." (to describe itchy ears)
- "It (my throat) feels thick."
- "It feels like a bump is on the back of my tongue (throat)."

If you suspect that your child is having an allergic reaction, follow your doctor's instructions and treat the reaction quickly.

Learn more about treatment at
www.foodallergy.org/treating-an-allergic-reaction.



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