

HEALTH CARE PLAN*

CELIAC DISEASE

Student name:

Gluten Intolerance

D.O.B.:

Cannot consume foods with gluten:

Address:

wheat, rye, barley and oats

Physician:

Teacher:

GOALS: The student will participate in all program activities with modifications as necessary.

All appropriate staff will be trained to assist the child to avoid foods and classroom materials that contain gluten.

ASSESSMENT: To be completed by school nurse prior to entry to school

Medical diagnosis: Celiac disease – autoimmune gastrointestinal disorder

Medical history:

Student's signs and symptoms of exposure to gluten (mild to severe): Ingestion of foods containing gluten could cause gastrointestinal symptoms such as immediate stomach cramps, bloating, vomiting, and diarrhea. Long-term exposure could damage the lining of the small intestine with resultant malabsorption and malnutrition. Student-specific symptoms: _____

Student's level of knowledge of the disorder, ability to avoid gluten, alert others to symptoms of possible exposure:

1. Non-verbal _____
2. Low: _____
3. Intermediate: _____
4. High : _____

Modifications to program environment-(**check appropriate steps, delete inappropriate steps**):

1. Student's parents will be provided access to lunch menus and ingredient lists for all cafeteria foods.
2. School food service will provide gluten-free bread and cereal products for the student when requested by parents.
3. Student will eat only foods brought from home or previously approved by parents.
4. Student may eat pre-approved cafeteria foods
5. Student's parents will send a supply of non-perishable snacks to be kept in the classroom for student to eat in the event that he/she does not have a snack from home. Parents will also provide non-perishable lunch foods to be kept in the Office

6. Lunch tables in cafeteria/snack tables in classroom will be thoroughly washed before and after meals to remove offending foods.
7. Student Alert/information sheet with picture and instructions on materials to avoid and action steps to take in case of an exposure will be kept in the Main Office, Classroom (substitute file), Cafeteria and be distributed to all teachers and staff members who may have contact with the student
8. The student will have unlimited access to bathroom facilities
9. Staff members will be trained annually to assist the student to avoid gluten, and to respond appropriately in the case of suspected exposure or development of symptoms of a reaction.
10. Parents will be immediately informed of any suspected exposures/reactions.
11. Classroom activities/lessons involving materials containing gluten will be approved by student's parents before she/he participates. Accommodations will be made as necessary. The student will be reminded to wash his/her hands after contact with gluten-containing materials.
12. Classroom celebrations involving food will be pre-approved by parents. Parents may choose to send in gluten-free treats for student to eat on these occasions.
13. Field trips will be discussed with parents in advance so arrangements for safe food consumption, adequate bathroom access can be made.
14. Additional accommodations needed:

Notes:

School nurse signature _____ Date _____

Parent/guardian signature _____ Date _____

Student signature _____ Date _____

Teacher signature _____ Date _____

***This Health Care Plan and any nurse delegation related to this plan are for use during regular school hours (8:10 a.m. – 3:20 p.m.). Medication questions outside of regular school hours need to be referred to the child's parents, Poison Control or 911. If a parent can attend a before/after school activity, they can assume responsibility for the medication.**