LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé
et de la Sécurité sociale

Direction de la santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

PAI - Individualised Support Plan
FOOD ALLERGIES

⚠ This interactive page requires Adobe Acrobat® Reader® version 8.1.3 or higher. The latest version of Adobe Acrobat Reader for all systems (Windows, Mac, etc.) can be downloaded for free on the Adobe Systems Incorporated website.

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The information about you collected from this form needs to be processed by the public administration concerned.
That information is kept by the administration in question for as long as it is required to achieve the purpose of the processing operation(s).
Your data will be shared with other public administrations that are necessary for the processing of your application. For details on which departments will have access to the data on this form, please contact the public administration you are filing your application with.
Under the terms of Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, you have the right to access, rectify or, where applicable, remove any information relating to you. You are also entitled to withdraw your consent at any time.
Additionally, unless the processing of your personal data is compulsory, you may, with legitimate reasons, oppose the processing of such data.
If you wish to exercise these rights and/or obtain a record of the information held about you, please contact the ***Ministry of Health****. If the contact details of the competent service are not indicated, you can contact the Data Protection Officer at the* ***Ministry of Health*** *by email at info_donnees@ms.etat.lu. You are also entitled to file a claim with the National Commission for Data Protection (Commission nationale pour la protection des données), headquartered at 15, boulevard du Jazz, L-4370 Belvaux.*

1. Input

Fields marked with an * are mandatory

Identity of the applicant

Photo

ONLY for School Medical Service:

Child's/Student's family name(s):*

Child's/Student's first name(s):*

Nat. identification number(matricule):*
(or date of birth if no id number)

Cycle / class:

School/SEA:*

Place/Location:*

Name(s) of legal representative/parents:*

Address:*

Telephone:

Email address:

MSA_DSA_PAI-AA_E_202002_6

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Delegation of care

Fields marked with an * are mandatory

I,* _____

the undersigned, legal representative or adult student, request for my child or myself the implementing of an Individualised Support Plan (PAI) based on the medical prescription and emergency intervention protocol established by

Dr* _____

I authorise that this document be made known and applied by the people in charge of the student/child or myself : school, school health team, day care centre/SEA, SePAS.
It is my responsibility:

- to check the expiry date of medicines
- to replace them as soon as they reach the expiry date
- in the event of a change in the medical prescription, to inform the people responsible for the child/student and the school health team

Signature (mandatory)

Place:* _____

Date:* _____

Signature of legal representative or adult student:* _____

Prescribing physician

Name:* _____

Date:* _____

Signature:* _____

For the doctor at the National Health Directorate - Department for School Medicine and Health of Children and Young People

PAI received on: _____

forwarded to: _____

on: _____

Signature: _____

MSA_DSA_PAI-AA_E_202002_6

Child's/Student's family name(s): _____ Nat. identification number: _____

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2. Supervisory staff

School health team	Name	Job title	Tel. no.
Headteachers	Name	Job title	Tel. no.
Supervisory staff at day-care centre	Name	Job title	Tel. no.
SePAS/ESEB	Name	Job title	Tel. no.
Others	Name	Job title	Tel. no.

3. Doctors treating the child

Family doctor (GP)	Name	Address	Tel. no.
Specialists	Name	Address	Tel. no.

Child's/Student's family name(s): _____ Nat. identification number: _____

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4. Transmission of the PAI / Concertation meeting

Information session:

Date:

Attendance list - People who have knowledge of the PAI

(give names and job titles of all people who have knowledge of the PAI)

Job title	Family name/First name	Signature	Date
Head teacher			
Educator			
Person in charge of the day-care centre			
Staff at day-care centre			
SEPAS			
ESEB			
Others			
Others			
Others			

For the School Health Team

A copy of the PAI has been handed to:

Date:

IMPORTANT: Instructions for staff responsible for the child/student:

- **Please inform the school principals in basic/secondary education establishments, the teachers, the supervisory staff and the supply teachers of the existence of this document.**
- **Send a copy of this page to *Division de la Médecine scolaire* (by post to: 20 Rue de Bitbourg, L-1273 Luxembourg-Hamm) after the people concerned have read the PAI and their signatures have been obtained.**

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5. Conditions for support

A copy of this form is to be given to the providers of school catering services that cater for education and care establishments and private nurseries (crèches).

Child's food allergy(ies):

Food(s)/Allergen(s) that must be excluded :	

A) School/day-care structure catering (school canteen/SEA)

☐ **Basic allergen avoidance:** The foods listed above must be excluded as an ingredient from the child's diet. Traces of the foods listed above may be present.

☐ **Strict allergen avoidance:** The foods listed above, including even their unintended presence (traces as a result of cross-contamination), are excluded from the child's diet. The child/student will eat food provided by the parents (lunchbox) or can eat a meal certified as "allergen-free" (provided by a specialised company).

Note: It is the responsibility of the school catering provider to determine, together with the parents, what form the student will get his meal, depending on the internal possibilities and procedures of the various care structures.

B) Snacks (at school/SEA)

☐ **Basic allergen avoidance**

☐ **Strict allergen avoidance** (snacks provided by the parents)

☐ Distribution of washed fresh fruit and vegetables is allowed (except those foods to be excluded)

C) Art and craft activities, cookery workshops

☐ Contact with the following food(s) must be avoided:

☐ No restriction

☐ Other:

D) Any other arrangements:

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s): Nat. identification number:

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6. Instructions

1. Emergency kit

PLACE A COPY OF THIS DOCUMENT IN THE EMERGENCY KIT

Content / Medicines	Expiry date
Location	
School ☐	
Day-care centre/SEA ☐	
Other ☐	

- **IF THE SAMU EMERGENCY SERVICE IS CALLED, INFORM THEM OF THE EXISTENCE OF THIS DOCUMENT**
- **INFORM THE PARENTS**
- **THE EMERGENCY KIT MUST FOLLOW THE CHILD ON ALL JOURNEYS OUTSIDE THE SCHOOL**

2. USE OF ADRENALIN AUTO-INJECTOR

☐ **YES** **(please fill in page 7 or 8)**

☐ **NO** **(please fill in page 9)**

Child's/Student's family name(s): _____ Nat. identification number: _____

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7a. EMERGENCY ACTION PLAN – FOOD ALLERGIES

If use of an **ADRENALIN AUTO-INJECTOR** is necessary, and in case of **FASTJEKT** or **EPIPEN**, please fill in this page.

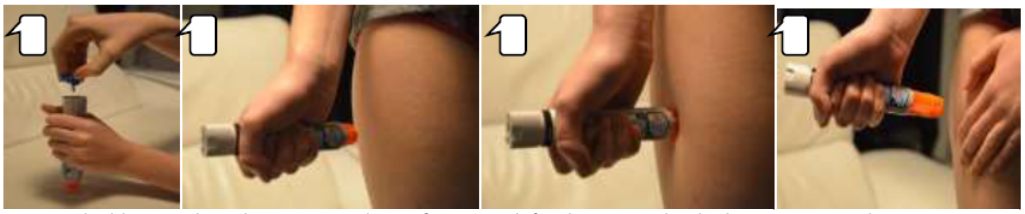
WHILE EATING OR JUST AFTER EATING:

SEVERE REACTION:

- Hoarse voice, voice changes
- Difficulty speaking
- Difficult breathing, wheeze, cough
- Severe abdominal pain and/or vomiting
- Feeling unwell, discomfort, faintness

WARNING!
IT MAY BE SERIOUS.
QUICKLY, PLEASE DO THE RIGHT THINGS NOW

1. INJECT FASTJEKT or EPIPEN:



Remove the blue cap | Place the orange end 5 cm from the top to the outer thigh, at a right angle | Push firmly against the thigh until a click is heard, and hold in place for 10 seconds | Massage the injection site for 10 seconds

2. CALL THE SAMU EMERGENCY SERVICE 112

3. Lay the child down and elevate the legs, or let the child sit up if breathing is difficult.
2nd injection in other thigh if no improvement after 10-15 minutes. ☐ **YES** ☐ **NO**

4. BREATHING ASSISTANCE

- **Short-acting beta agonist (bronchodilatators) administered using a spacer device:** ____
- **Corticosteroid administered orally:** ____

MILD REACTION:

- Itchy mouth, runny nose
- Swollen lips
- Hives, itchy skin rash
- Mild stomach ache, nausea

WARNING!
NORMAL SPEAKING AND BREATHING

1. Antihistamine: ____

2. Keep the child under observation and notify the parents

3. If the child's condition deteriorates: *treat as a severe reaction*

*protocol validated by the Luxembourg Society for Allergology and Immunology

Signature

Place:* ____

Date:* ____

Stamp of the doctor:* ____

Child's/Student's family name(s): ____ Nat. identification number: ____

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7a. EMERGENCY ACTION PLAN – FOOD ALLERGIES

If use of an **ADRENALIN AUTO-INJECTOR** is necessary, and in case of **ANAPEN**, please fill in this page.

WHILE EATING OR JUST AFTER EATING:

SEVERE REACTION:

- Hoarse voice, voice changes
- Difficulty speaking
- Difficult breathing, wheeze, cough
- Severe abdominal pain and/or vomiting
- Feeling unwell, discomfort, faintness

WARNING!
IT MAY BE SERIOUS.
QUICKLY, PLEASE DO THE RIGHT THINGS NOW

1. INJECT ANAPEN:

Remove the black cap protecting the needle by pulling hard

Press firmly against the thigh

Pull the grey safety cap off the red firing button

Keep pressing against the thigh, and press on the firing button (you should hear it click); hold down for 10 seconds, then massage the injection site

2. CALL THE SAMU EMERGENCY SERVICE 112

3. Lay the child down and elevate the legs, or let the child sit up if breathing is difficult.
2nd injection in other thigh if no improvement after 10-15 minutes. ☐ **YES** ☐ **NO**

4. BREATHING ASSISTANCE

- **Short-acting beta agonist (bronchodilatators) administered using a spacer device:**
- **Corticosteroid administered orally:**

MILD REACTION:

- Itchy mouth, runny nose
- Swollen lips
- Hives, itchy skin rash
- Mild stomach ache, nausea

WARNING!
NORMAL SPEAKING AND BREATHING

1. Antihistamine:

2. Keep the child under observation and notify the parents

3. If the child's condition deteriorates: *treat as a severe reaction*

*protocol validated by the Luxembourg Society for Allergology and Immunology

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s):

Nat. identification number:

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7c. EMERGENCY ACTION PLAN – FOOD ALLERGIES

If use of an **ADRENALIN AUTO-INJECTOR** is **NOT** necessary, please fill in this page.

WHILE EATING OR JUST AFTER EATING:

MILD REACTION:

- Itchy mouth, runny nose
- Swollen lips
- Hives, itchy skin rash
- Mild stomach ache, nausea

WARNING!
NORMAL SPEAKING AND BREATHING

1. Antihistamine: _____

2. Keep the child under observation and notify the parents

3. If the child's condition deteriorates: ***treat as a severe reaction***

SEVERE REACTION:

- Hoarse voice, voice changes
- Difficulty speaking
- Difficult breathing, wheeze, cough
- Severe abdominal pain and/or vomiting
- Feeling unwell, discomfort, faintness

WARNING!
IT MAY BE SERIOUS.
QUICKLY, PLEASE DO THE RIGHT THINGS NOW

1. CALL THE SAMU EMERGENCY SERVICE 112

2. BREATHING ASSISTANCE

- **Short-acting beta agonist (bronchodilatators) administered using a spacer device:** _____
- **Corticosteroid administered orally:** _____

3. Antihistamine: _____ ***(If not already administered for a slight reaction)***

*protocol validated by the Luxembourg Society for Allergology and Immunology

Signature

Place:* _____

Date:* _____

Stamp of the doctor:* _____

Child's/Student's family name(s): _____ Nat. identification number: _____