LOS ANGELES UNIFIED SCHOOL DISTRICT
Porter Ranch Community School
12450 Mason Avenue, Porter Ranch, CA 91326
Telephone: (818) 709.7100 Fax: (818) 993.1363

RE: Food or Other Severe Allergy

Dear Parent/guardian:

Our school is committed to ensuring a safe and healthy environment for all students and staff. You have indicated that your child has a food or other severe allergy. To plan for and provide safe care for your child in the school setting, please provide the following:

1. Written instructions for emergency medication administration in the event that your student has an allergic reaction while at school. Please return the **"Request for Medication During School Hours"** form, **"Parent Consent and Healthcare Provider Authorization for Emergency Treatment of Anaphylaxis: Epinephrine Auto Injector"** form, and protocol for "**Emergency Treatment of Anaphylaxis Epinephrine Auto-Injector"** (attached), completed and signed by your child's health care provider.
2. **Epinephrine auto-injector**, if prescribed (e.g., EpiPen®), or other medication to be used if an allergic reaction occurs. The medication must have the original pharmacy label and you are required to replace medications after use or expiration.
3. "**Special Diets Request**" form (attached), completed and signed by your child's treating physician. This form will need to be returned to the cafeteria manager for review.

Please work with the school staff, especially the school nurse, who will complete an individual health care plan for your child. This plan will include an "Emergency Care Plan" which we ask you to review and sign. The school nurse will train school staff in allergic reactions and how to administer the emergency medication ordered by your health care provider.

You can also help your child in addressing food and other allergies by teaching them:

- ☐ safe and unsafe foods
- ☐ how to avoid exposure to unsafe foods (e.g., do not share food with other children)
- ☐ symptoms of allergic reactions
- ☐ how and when to tell an adult they may be having an allergy-related problem

Teachers appreciate assistance with special events/classroom parties where food may be served, and it is a good idea to provide a safe/alternative snack supply. We would welcome an opportunity to meet with you and discuss your child's allergy and how we can implement the individual health care plan in this school. The school nurse is available on (Day or week), (Hours) at (phone number).

Sincerely,

Jennifer Press, RN, BSN, CPN

School Nurse

LOS ANGELES UNIFIED SCHOOL DISTRICT
Policy bulletin

LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

Student Name_____ _____ _____ _____
Last First Gender Birth date School

Name of Medication_____Start date_____

Dosage prescribed_____Time schedule at school_____Route _____

How long is medication to be taken ☐ 1 Year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of Medication or diagnosis_____ICD Code _____

Licensed Health Care Provider's Recommendations (Check where applicable)

☐ The medication may have adverse side effects (explain) _____

☐ Special instructions and/or comments_____

The student for whom this medication is prescribed is under my care.

_____ _____ _____
Print name/Title Signature Date

_____ (___)_____
Address City State Zip Code Telephone

Print name of Supervising Physician_____(NP, Midwife, PA)

Furnishing Number_____(NP/Midwife)

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
(To be completed by parent/guardian)

I request that my child_____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

_____ _____ _____
Date Signature of Parent/Guardian/Student 18 years Printed Name

(___)_____ (___)_____ (___)_____
Home Telephone Work telephone Cellular telephone

Licensed Nurse Acknowledgement of Complete and Accurate Order			
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

February 2023

DISTRICT PROCEDURES REGARDING MEDICATION TAKEN DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider
   - Student's full name
   - Physician's name
   - Dosage, schedule, and route
   - How long medication is to be taken? 1 year or short term: (Date medication is to be discontinued or number of days medication is to be administered.)

2. In addition to a home supply, parent/guardian may request a second labeled bottle from the pharmacy for school use.

3. Non-prescription (over the counter) medications that have been authorized by this request may be administered at school only if the medication is provided in the original container.

4. Request for Medication to be Taken During School Hours must be renewed annually.

5. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Medication to Be Taken During School Hours when there is a change in the student's medication, health status or authorized health care provider.

6. The school administrator or the administrator's designee will assume responsibility for placing the medication in a locked cabinet, storage unit or locked refrigerator.

7. The school administrator, the administrator's designee, or school nurse will assume responsibility for returning unused medication to the parent/guardian at the end of the student's school year.

8. If medication must be taken while a student is on a field trip, arrangements must be made through the school nurse.

9. All injectable medications require special arrangements.

   a. Injectable medications, such as insulin, used on a regular or as needed basis must be administered by licensed health care providers and require special arrangements.

   b. Injectable medications, which are to be given on an emergency basis, require special arrangements and training of volunteer school staff by the credentialed school nurse/physician.

10. Each medication requires a separate written authorization.

LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
District Nursing Services

Parent Consent and Healthcare Provider Authorization for
EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO INJECTOR at School and School-Sponsored Events

Student:	**DOB:**	**Grade:**
School:	**Phone:**	**Fax:**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR
EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO INJECTOR IS ATTACHED.

1. Check one:

☐ I have reviewed and approved the attached standardized procedure as written.

☐ I have reviewed and approved the attached standardized procedure as written with the attached modifications.

☐ I **do not** approve of the standardized procedure. I have attached my alternative procedure and recommendations.

2. Specific Allergens that cause anaphylaxis: _____
3. Common signs and symptoms: _____
4. Typical reaction time after exposure: _____
5. Special Instructions: _____

Authorized Healthcare Provider Authorization for
EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name:**_____ **Signature:**_____ **Date:**_____

Phone:_____ **Address:**_____ **City**_____ **Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Parent Consent for Authorization for
EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR in School Setting

I, the undersigned, the parent/guardian of the above named student, request that the specialized physical healthcare procedure be administered to my child in accordance with state laws and regulations. I will :

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status, or attending healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization;
4. provide new written consent/authorization yearly.

I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian (Print Name):_____ **Signature:**_____ **Date:** _____

Home Phone:_____ **Work Phone:**_____ **Cell:** _____

Licensed Nurse Acknowledgement of Complete and Accurate Order

_____	_____	_____	_____
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

February 2023

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services Division
District Nursing Services

EMERGENCY TREATMENT OF ANAPHYLAXIS
EPINEPHRINE AUTO-INJECTOR

I. GENERAL GUIDELINES

A. PURPOSE

1. To counteract the adverse reaction to an allergen.
2. To provide immediate treatment and access to emergency medical care.

B. GENERAL INFORMATION

1. Anaphylaxis – A severe, systemic, potentially life threatening allergic reaction affecting multiple body systems.
2. Anaphylactic reaction can occur immediately or be delayed up to two hours or more after exposure. In some cases, symptoms resolve, then recur 8 to 12 hours later (biphasic reaction) and can be more severe.
3. **Causes of Anaphylaxis** may include, but are not limited to:
   a. Stinging insects – wasps, yellow jackets, hornets, bumble bees, honeybees.
   b. Foods, especially high-protein foods – most common: seafood (shellfish, fish), nuts (especially peanuts), fruit, wheat, milk, eggs, soy and food additives.
   c. Air inhalants – pollens, mold, animal dander or secretions, house dust mites.
   d. Medications.
   e. Latex – commonly found in occupational therapy elastic bands, balloons, rubber balls or toys, art supplies, science supplies (e.g. microscope eye pieces, pencil erasers, computer mousepads, gloves, tapes, elastic bandages).
   f. Chemicals.
   g. Exercise and idiopathic causes (unknown reason)
4. Signs and Symptoms of Anaphylaxis:
   a. **Mouth:** Itching, tingling, or swelling of lips, tongue, or mouth.
   b. **Skin:** Itching or burning, hives, rash, swelling of face or extremities, flushing.
   c. **Stomach:** Nausea, abdominal cramps, vomiting, diarrhea.
   d. **Throat:** Tightening of throat, hoarseness or change of voice, hacking or repetitive coughs.

e. **Lung:** Shortness of breath, wheezing, chest pain/tightness, nasal flaring or complaints of not being able to "catch my breath".
f. **Heart:** Weak or thread pulse, low blood pressure, paleness, blueness, general body weakness, dizziness, fainting/unconsciousness.
g. **Other:** Localized or general body swelling apprehension, anxiety, red/itchy/watery eyes, excessive sneezing, nasal congestion.

5. Allergic reactions may also be delayed and present as joint pain, aches and/or localized inflammation days after exposure. In these cases, the student should be referred to their licensed healthcare provider.
6. Epinephrine is the most effective treatment of anaphylaxis. A common side effect is an increased heart rate and slight tremor.
7. There are no contraindications to the use of epinephrine for life-threatening allergic reactions. An antihistamine, corticosteroid or bronchodilator may be prescribed to further reduce symptoms after emergency treatment.
8. Epinephrine cartridge window should be examined periodically to ensure that the solution is colorless, contains no floating particles and has not expired. Solutions that are discolored, contain particles or are expired must be replaced.
9. **Call 911 for all individuals who receive Emergency Epinephrine.**
10. The school nurse in collaboration with the healthcare provider, the school staff, parents, and student develops an emergency care plan.

C. PERSONNEL
1. School nurse.
2. Designated and trained school personnel with current CPR certification under indirect supervision of the school nurse.

D. EQUIPMENT
1. Provided by parent:
   a. Epinephrine Auto-Injector(s) i.e. EpiPen and EpiPen Jr. Auto-Injector(s)
   b. Other prescribed medications.
   c. Antiseptic wipes if ordered (e.g. alcohol wipes)
2. Provided by the school:
   a. Disposable non-latex gloves
   b. Sharps container

II. PROCEDURE

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS
1. Determine whether the student has signs or symptoms of anaphylaxis	Stay with the student. Remain calm and reassure student. Calming reduces distribution of allergen in the body. Student is not to be moved unless in immediate danger. Lay student down if tolerated, with lower extremities elevated.
2. **Ask for HELP** Direct other adult to call 911 emergency services immediately.	Obtain medication from storage location if student does not carry the medication. Notify school administrator and school nurse. School nurse or school administrator will notify the parent.
3. If able, wash hands and put on disposable gloves.	Hand sanitizer may be used, if water is not available.
4. Administer Epinephrine Auto-Injector a. Open and remove the EpiPen from the carrier tube. b. Tip and slide the Auto-Injector from the carrier tube. c. Grasp EpiPen with fist around unit with the orange tip facing downward. d. Pull off the BLUE Safety Release Cap without bending or twisting it. e. Firmly push the orange tip against the middle outer thigh (90 degree angle) until it clicks. f. HOLD firmly in place against the thigh for 10 seconds to deliver the medicine. g. Remove the auto-injector from the thigh. h. Massage the injection site for 10 seconds. i. Place EpiPen, needle first back into carrier tube.	Epinephrine acts immediately, but the effects last only 15-20 minutes. Student may feel heart pounding. This is normal. Do NOT remove safety cap release until ready to use auto-injector. EpiPen can be injected through clothing. Never put thumb, fingers, or hand over the tip of auto-injector. The orange tip will extend to cover the needle. Place used auto-injector back in the carrier tube. Note the time Epinephrine was given and vital signs if taken.

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS
5. While waiting for Paramedics: a. Stay with the student and observe for signs of shock. b. Cover the student with blanket as needed to maintain normal body temperature. c. Monitor airway and breathing. d. Verify that 911 emergency services has been called. e. Provide CPR if needed. f. If trained, take vital signs.	Signs of Shock are: • Rapid, shallow breathing • Cold, clammy skin • Rapid, weak pulse • Dizziness, fainting, or weakness
6. If the student self-administers EpiPen, trained school personnel need to be notified **IMMEDIATELY** after self-administration of medication. Call **"911"** Emergency services.	School personnel are to remain with student and contact school nurse and site administrator.
7. If the reaction is the result of an insect sting, after administering the medication, remove stinger by scraping sideways with a fingernail or a flat, firm object, such as a credit card. Ice pack may be applied to the affected area.	Do **NOT** push, pinch, or squeeze the stinger area. This may cause more venom to be released.
8. Paramedics may administer additional epinephrine when they arrive.	Expended auto-injector in the carrier tube is given to paramedic. Provide written information: Dose, route, time(s) of medication administration, vitals if taken and all information regarding exposure to allergen and student's reaction. A copy of emergency card maybe given to paramedics.

ESSENTIAL STEPS	KEY POINTS AND PRECAUTIONS
9. Document information on the student's electronic health record. Document on iSTAR – Incident Report Online	Individual who does not have access to the electronic record must document on paper log (See attachment A.) Site Administrator/School Nurse initiate iSTAR report. School Nurse will provide follow-up report outcome to the site administrator and review the incident report form.

APPROVED:

March 1, 2019
Date

Rosina Franco, MD
Senior Physician, Student Medical Services

Ron Tanimura, Ed.D
Director, Student Medical Services

Sosse Bedrossian, MSN, MA, RN, FNP
Director, District Nursing Services

REFERENCES:

California School Nurses Organization. The Green Book: California Guidelines for Specialized Physical Healthcare Procedures in School Settings, Section 3, 2nd Edition (4/11). Sacramento, CA.

California Department Of Education - Health Services and School Nursing
http://www.cde.ca.gov/ls/he/hn/epiadmin.asp

http://www.uptodate.com/contents/use-of-an-epinephrine-autoinjector-beyond-the-basics

INTEROFFICE CORRESPONDENCE
Los Angeles Unified School District

TO: Food Service Manager, Nurse, Parent/Guardian **DATE:** May 18, 2022

FROM: Food Services Division

SUBJECT: Special Diet and Milk Substitution Requests

After completed special diet forms are submitted to Food Services and processed, a Nutrition Specialist completes the diet, and the Food Service Manager (FSM) informs all parties when special diet meals start. Below is information on different special diet requests:

1. **First-Time Special Diet Request**:

   A. Parent completes Section A of the **LAUSD Medical Statement to Request Special Meals* (Special Diet Request Form), gives the form to a health care professional (Licensed Physician, Physician Assistant or Nurse Practitioner) to complete section C, and turns in completed form to FSM.

   B. Please note that special meals are not provided to accommodate food preferences or religious convictions.

**Special Diet Form consists of two pages with instructions and information on page 2.*

2. **Renewing Last Year's Special Diet Request**:

   A. If there are **NO CHANGES** to the student's special diet from last year, then the parent can renew the diet by signing and dating the bottom of the special diet form filed in the cafeteria.

   B. If there are changes to the student's special diet from last year, then parent must submit a new Special Diet Form.

3. **Milk Substitution**:

Beverage Requested	Action or Form Needed
Almond or Rice Milk or Juice	Parent completes section A on the Special Diet Form. A health care professional completes section C. Parent gives the completed form to Food Service Manager.
Soy Milk	Parent completes the *Parental Request to Substitute Soy Milk for Fluid Milk and* gives completed form to FSM. **Only parent/guardian signature needed.**
Lactose-Free Milk	No **form needed**. Inform the Food Service Manager which meals the student should receive this milk.

Nutrition Specialist Contact Information		
District	**Nutrition Specialist**	**Email**
Northeast, Northwest	Kim Nguyen	duyen.nguyen@lausd.net
Central	Homa Hashemi	homa.hashemi@lausd.net
West	Ivy Marx	ivy.marx@lausd.net
East, South	Kayley Drain	kayley.drain@lausd.net

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LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS

A. Parent/Guardian: Complete boxes 1-6 *(Padres/tutores: Complete recuadros 1-6)*

1. Student Last Name *(Apellido)*	2. Student First Name *(Nombre del estudiante)*	3. Date of Birth *(Fecha de nacimiento)*

4. Parent/Guardian Name *(Nombre de los padres/tutores)*	5. Parent/Guardian Phone # *(Número de teléfono del los padres/tutores)*: ☐ Home *(Casa)* / ☐ Cell *(Celular)*: ( ) - Email Address *(Correo Electrónico)*:

6. Meals Eaten at School *(Marque las comidas que su niño/a come en la escuela)*
☐ **Breakfast** *(Desayuno)* ☐ **Lunch** *(Almuerzo)* ☐ **Snack** *(Merienda)* ☐ **Supper** *(Cena)*

B. Food Services Manager (FSM): Complete boxes 7-16

7. School Name	8. Loc. Code #	9. District	10. Kitchen Type ☐ PREP ☐ NNC

11. LAUSD Student ID Number (ID# not available for EEC students)	12. Area Food Service Supervisor Name (AFSS):

13. FSM Name	14. FSM Email @lausd.net	15. Cafeteria Phone # ( ) -	16. Check box if this an EEC Student? ☐

C. State Licensed Healthcare Professional (Licensed Physician, Physician Assistant or Nurse Practitioner): Complete 17-30

17. Description of Child's Physical or Mental Impairment Affected: *(Describe how the physical or mental impairment restricts the child's diet)*

18. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: *Describe specific diet or accommodation*

19. Indicate Special Texture if Needed: ☐ **Ground** ☐ **Pureed** ☐ **Chopped Finely** ☐ **Chopped Dime-Sized** ☐ **Chopped Nickel-Sized** ☐ **Chopped Quarter-Sized**

20. Foods to be Omitted and Substitutions *(List specific foods to be omitted and specific foods to include. Attach separate sheet if needed)*

A. Foods to be Omitted	B. Suggested Substitutions *(Foods to Include)*

21. Adaptive equipment to be used *(If applicable, describe specific equipment required to assist child with dining):*

22. & 23: Only complete if applicable to student.

22. Milk/Dairy Allergy or Intolerance: This student is NOT able to eat/drink the following (check off all that apply):
☐ Fluid Cow's Milk ☐ Lactose Free Cow's Milk ☐ Baked Goods containing Milk/Dairy products
☐ Yogurt ☐ Cheese ☐ Condiments containing Milk/Dairy products

23. Egg Allergy or Intolerance: This student is NOT able to eat the following (check off all that apply):
☐ Scrambled Eggs/Egg Patties ☐ Condiments containing eggs *(mayonnaise, salad dressings, etc.)*
☐ Baked Goods containing eggs ☐ Foods containing eggs as a minor ingredient

24. Name of State Licensed Healthcare Professional:	25. Signature of State Licensed Healthcare Professional:	26. Date:

27. Check One: ☐ MD/DO ☐ PA ☐ Nurse Practitioner	28. Healthcare Professional's Phone #: ( ) -

29. *If applicable*, Name of Registered Dietitian following student:	30. Dietitian Phone #: ( ) -

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities requiring alternative means of communication for program information(e.g. Braille, large print, audiotape, American Sign etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: USDA Office of the Assistant Secretary for Civil Rights,1400 Independence Ave.S.W.,Washington, D.C. 20250-9410; fax (202)690-7442/ e-mail:program.intake@usda.gov. This institution is an equal opportunity provider.

INSTRUCTIONS AND INFORMATION FOR LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND OTHER RELATED FORMS

A. FOOD SERVICE MANAGER AND PARENT/GUARDIAN:

1. FSM provides ***LAUSD Medical Statement to Request Special Meal Form*** to the parent/guardian.
2. Parent/Guardian completes Section "A".
3. Food Service Manager (FSM) completes Section "B".
4. Healthcare Professional completes Section "C"
5. Parent returns form to FSM, who checks that all sections of the form are complete.
6. If incomplete, FSM returns form to parent for completion.
7. FSM can accept a doctor's medical statement identifying a student's special diet needs.

   The statement must include the following:

   a) Student Date of Birth
   b) Student ID Number
   c) Parent/Guardian Name
   d) School Name
   e) FSM Name, Email Address
   f) Cafeteria Phone Number

8. FSM scans and emails completed form to specialdiet@lausd.net.
9. Nutrition Specialist (NS) emails FSM an approved diet or reason why a request could not be fulfilled.
10. FSM files the special diet original in the cafeteria and give a copy to the parent/guardian, school nurse, and Section 504 coordinator.
11. FSM orders and provides all special meals including Newman Nutrition Center meals.
12. If parent and/or nurse requests additional nutrition information about meals, FSM can direct them to the LAUSD website at http://achieve.lausd.net/Page/11718 for the monthly menu, *Food Allergen and Ingredient List*, *Nutrient Analysis* and *Carbohydrate Count*.
13. Special meals are not provided to accommodate food preferences or religious convictions.
14. If soy milk is needed, FSM provides parent with *Parental Request to Substitute Soy Milk for Fluid Milk* form.
15. If special diet is discontinued, FSM provides parent the *Statement to Discontinue Special Diet* form.

B. LICENSED HEALTH CARE PROFESSIONALCOMPLETING SECTION C:

1. The State Licensed Healthcare Professional signing this form must complete all boxes under Section C; however, boxes 22 and 23 are only required if the student has a dairy or egg allergy or intolerance.
2. Specific details are required for items 17 and 18. Additional pages may be attached to this form if necessary.
3. If all sections are not complete, the form will be returned, and **the special diet will not be processed.**
4. A state licensed healthcare professional in California is a **Licensed Physician**, **Physician Assistant** or **Nurse Practitioner**.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and the ADA Amendment Act of 2008: **A person with a disability** is defined 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. **Physical or mental impairment** means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. **Major life activities** include, but are 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 bodily functions** have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions. **"Has a record of such an impairment"** means a person has or has been classified (or misclassified) as having a history of mental or physical impairment that substantially limits one or more major life activities.

rev 3.19.21 ilm