Health Services

Allen ISD Allergy/Anaphylaxis Plan

Student Photo

Student name________________________ **D.O.B.**__________ **Grade/Campus** _______________

Healthcare Provider: ___________________ **Phone:**___________________ **Teacher:**__________

ALLERGY: *(check appropriate)* **To be completed by Health Care Provider**

☐ History of Asthma *(increased risk for severe reaction)* ☐ Insects (list):

☐ Foods (list):

☐ Latex (circle): Type I (anaphylaxis) Type IV (contact dermatitis) **Weight:** __________

☐ Medications (list):

☐ Other (list/describe):

Symptoms	Action
Any SEVERE SYMPTOMS or more than one MILD SYMPTOM: **LUNG: short of breath, wheeze, cough** **HEART: Pale, blue, weak pulse, dizzy, passing out** **THROAT: itching, tightness/closure, hoarseness** **MOUTH:** Itching, swelling of lips and/or tongue **SKIN:** Many hives over body, widespread redness **GUT:** Vomiting, diarrhea, cramps **OTHER:** anxiety, confusion, feeling of dread/something bad is about to happen	1. **INJECT EPINEPRHINE IMMEDIATELY** 2. **Call 911** 3. Place in supine position or seated upright position and monitor closely 4. Give additional medications --Inhaler (bronchodilator) if asthma --antihistamine 5. Repeat Epinephrine in 5 to 15 minutes if symptoms persist/worsen *Antihistamines & inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHRINE.
ONE MILD SYMPTOM (involvement of only one system with NO respiratory or cardiovascular symptoms) **MOUTH:** Itchy mouth **NOSE:** Itchy/runny nose, sneezing **SKIN:** A few hives or localized redness; mild itch	1. Stay with student; monitor closely 2. If symptoms progress USE EPINEPHRINE (see above) 3. If no progression of symptoms administer antihistamine

MEDICATION

Epinephrine: ☐ EpiPen 0.3mg ☐ EpiPen Jr. 0.15mg ☐ Auvi-Q 0.3mg ☐ Auvi-Q 0.15mg
☐ Other/generic epinephrine (specify): ______________________________

Inhaler/bronchodilator: ____

(brand/drug) (dose/frequency)

Antihistamine:

☐ mild/one symptom after______minutes observation ______________________________

(brand/drug) (dose/frequency)

☐ severe reaction, following epinephrine, if able to swallow ______________________________

(brand/drug) (dose)

☐ other (specify): ____

SELF-ADMINISTRATION

☐ It is my professional opinion that this student **SHOULD** be allowed to carry and independently use their ☐ epinephrine auto-injector ☐ inhaler. This child has received instruction in the proper use of their medication and to inform a responsible adult if epinephrine is self-administered.

☐ It is my professional opinion that this child **SHOULD NOT** carry their: ☐ epinephrine auto-injector ☐ inhaler

Provider Print/Stamp: ______________ **Signature:** _________________ **Phone:**____________ **Date:** _______

Name: _______________________ Campus:____________

Parent/Guardian and Student

How does your child get home? ☐ Parent pick-up ☐ Daycare pick-up ☐ Walk ☐ Drives ☐ Bus #________

Before/after school programs/extracurricular activities: ☐ Kids Club ☐ Athletics ☐ Band ☐ Drill Team ☐ Cheer ☐ Other (list): ____

☐ Yes ☐ No I would like for my classmates and/or their parents to be aware of my child's food allergy.

***Elementary students**:* ☐ Yes ☐ No I would like for my child to sit in a Peanut/Nut/Allergen-Aware Zone in the cafeteria.

Student Self-Administration (initial each statement to indicate agreement):

______ I have been trained in the use of my ☐ epinephrine auto-injector ☐ inhaler and understand the signs and symptoms for which they are to be given.

______ I understand it is my responsibility to keep my medication with me during school, school activities and trips. I

______ will notify an adult **IMMEDIATELY** when epinephrine has been used (teacher, nurse, coach, etc.)

______ I will not share, leave unattended, or use my medication in a way other than for which it is prescribed.

______ I will inform the school nurse and my parents if my medication is lost, stolen, damaged or expired.

Student Signature (if self-administering)____ Date: ______________

Backup medication provided school? ☐ Yes ☐ No It is recommended that backup medication be stored with the school in case a student forgets or loses their medication. The school district is not responsible or liable if backup medication is not provided and student is without working medication when medication is needed. ***Your signature gives permission for the nurse to implement this health plan and to contact and receive additional information from your healthcare provider regarding the allergic condition(s) and prescribed medication.* Allergy School Health Plan *will be shared with school staff with legitimate educational interest.***

Parent/Guardian Signature: ________________________ Phone: _______________ Date: ________

Emergency Contacts	Relationship	Home Phone	Cell Phone

This Section for Staff Use Only

Interventions: (check box to indicate activities appropriate for the student)

Select	Staff/Campus Interventions/Activities	Date/Initials
	Notify teachers, office staff, coaches/sponsors/extra-curricular; instruct on prevention & avoidance	
	Notify cafeteria manager so food allergy alert can be placed on student's meal account	
	Provide cafeteria manager completed *Special Diet Request* form	
	Develop emergency response plan for administration of prescribed emergency medication	
	Implement latex precautions:	
	Assist teacher with classroom allergen safety; encourage allergen-aware class	
	Monitor environment and implement restrictions when:	
	Collaborate with staff to address issues that may be present during trips or off-campus locations	
	Notify lunch monitors/teachers about allergy and allergen-aware seating preference	
Select	**Student Interventions**	**Date/Initials**
	Instruct student on medication safety, including methods for assuring correct administration	
	Provide/review self-administration training with student who carries their □ epinephrine auto- injector □ inhaler	
	Reinforce/review student's medication self-carry responsibilities	
	Encourage the use of medical alert jewelry	
	Review/assess student's ability to identify allergen/potential sources and avoidance ability: □ independent □ requires supervision/assistance □ dependent	

Staff Trained to Administer:	1-	2-	3-

(Skills training checklist on file in clinic) **Outcomes:** Exposure to known allergens will be avoided at school and student will demonstrate age-appropriate self-care, including ability to identify and avoid allergen(s).

Campus RN signature/initials:______________________________Date: ________Phone: ____________