Grade: _______________ Student ID: ________________

Allergy School Health Plan

Student Photo

Student _______________________________ **Date of birth** _____________ **Weight** ___________

Emergency Contact/Phone: ____

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

History of anaphylaxis ☐No ☐Yes

History of asthma ☐No ☐Yes *(increased risk for severe reaction)*

☐ Latex ☐Type I (anaphylaxis) ☐Type IV (contact dermatitis)

☐ Foods (list):

☐ Insects (list):

☐ Medications (list):

☐ Other (list/describe):

SEVERE Allergy and Anaphylaxis Symptoms		Give epinephrine! Call 911
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, agitation, feeling of "doom"/something bad is about to happen	→	●Note time epinephrine injected. ●Keep student lying on back. If vomiting or having trouble breathing, roll onto side. ●Repeat epinephrine in 5 minutes if symptoms persist/worsen ●Give additional medications --antihistamine --Inhaler/bronchodilator *DO NOT use other medicine in place of epinephrine
MILD Allergic Reaction Symptoms may include: Itchy nose, sneezing, itchy mouth A few hives Mild nausea or mild stomach discomfort	→	Stay with student; monitor closely ●Give antihistamine (if prescribed) ●Call parent/school nurse ●If severe symptoms develop USE EPINEPHRINE

MEDICATION/DOSES

Epinephrine, intramuscular (list type): ________________________________ **Dose:** ☐0.15mg ☐0.3mg

☐If checked, student has extremely severe allergy to________________ Give epinephrine for MILD symptoms.

Inhaler/bronchodilator: ____

(brand/drug) (dose/frequency)

Antihistamine, by mouth:

☐ mild/one symptom after _______ minutes observation ____

(brand/drug) (dose/frequency)

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

(brand/drug) (dose)

Self-Administration *Texas law permits students to carry and use prescription epinephrine auto-injectors and inhalers at school*

(Backup medication at school is recommended in case a student forgets or loses their medication.)

☐This student has been instructed in the proper use of his/her emergency medication, and both the provider and the parent feel the student may carry and self-administer their ☐epinephrine auto-injector ☐inhaler at school.

☐Student needs supervision or assistance, and should **NOT** carry his/her emergency medication while at school.

______________________________ ___________________________ _____________ ________________________

(Physician/Provider Signature) **(Print Name)** **(Date)** **(Phone)**

Grade: ________________ Student ID: _________________

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: ☐ ROCK ☐ 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 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) **(Print Name)** **(Date)** **(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	

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).

Indicate Staff Trained to Administer Medication
(skills training checklists on file in campus clinic):

Campus RN signature/initials: _____________________/________ Date: ______________ Tel ______________________