Tuloso Midway ISD
ALLERGY ACTION PLAN

Student's Name: ______________________________

Allergy to: ______________________________

Date of Birth: __________ **Grade** _____ **Teacher:** ______________________

Asthmatic: ☐ **Yes* *Higher risk for severe reaction**

☐ **No**

I have instructed ______________ (student's name) in the proper way to use his/her Epipen/Twinjet. It is my professional opinion that ________________ (student's name) should be allowed to carry and self-administer his/her Epipen/Twinjet while on school property or at school-related events.

I, the parent of _______________ (student's name) agree with his/her physician to allow ________________ (student's name) to carry his/her Epipen/Twinjet. Upon doing this, I realize that the school clinic will not have his/her personal Epipen/Twinjet unless I supply the school with an extra one in case my child forgets his/hers. Parents are responsible for planning & providing emergency medication for activities outside of normal school hours.

For Self - Administration Only

Does this student have physician permission to self –administer this medication and to carry this medication on himself/herself? Yes___ No____

Has this student been trained in the signs and symptoms of minor and major reactions? Yes___ No___

Is this student capable of self-administering EpiPen/Twinjet? Yes___ No___

Can this be safely self-administered in the school setting? Yes___ No___

Does this student need the supervision of a designated adult? Yes___ No___

Has the student been trained in the self-administration of the EpiPen/Twinjet? Yes___ No___

Nurse Signature____

Signs of an Allergic Reaction

MOUTH................itching and swelling of the lips, tongue or mouth

THROAT..............itching and/or a sense of tightness in the throat, hoarseness and hacking cough

SKIN.....................hives, itchy rash, and/or swelling about the face or extremities

LUNG...................shortness of breath, repetitive coughing, and or/wheezing

HEART.................“thready” pulse, “passing out”

GUT......................nausea, abdominal cramps, vomiting, and/or diarrhea

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION:

1. If only symptom (s) are: ______________________________
   Give ______________________________
   Medication/dose/route
2. Call Mother: __________________ Father: __________________
   or emergency contact ______________________________

IF CONDITION DOES NOT IMPROVE WITHIN 10 MINUTES, FOLLOW STEPS 1-3 OF ACTION FOR MAJOR REACTION

ACTION FOR MAJOR REACTION:

1. If ingestion is suspected, and/or symptom (s) are: ______________________________
   immediately give ______________________________
   Medication/dose/route
2. Call EMS
3. Call Mother: __________________ Father: __________________
   or emergency contact: ______________________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMERGENCY MEDICAL SERVICES EVEN IF PARENTS CANNOT BE REACHED.

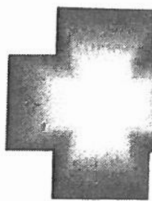
______________________________ Parent/Guardian's Signature

______________________________ Doctor's Signature

______________________________ Date

______________________________ Doctor's Phone No.

______________________________ Date



BEE STING ALLERGY

Student: ______________________ Grade: _______ School Contact: ____________________ DOB: ______________

Asthmatic: ☐ Yes ☐ No (increased risk for severe reaction) Severity of reaction(s): ______________________________

Mother: ______________________________ MHome #: __________ MWork #: ___________ MCell #: ___________

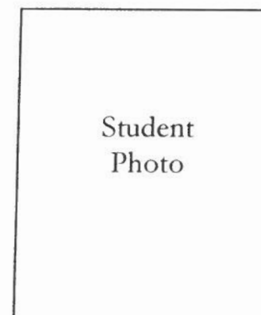
Father: ______________________________ FHome #: __________ FWork #: ___________ FCell #: ___________

Emergency Contact: __________________________ Relationship: ______________ Phone: ________________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.



Student Photo

STAFF MEMBERS INSTRUCTED: ☐ Classroom Teacher(s) ☐ Special Area Teacher(s) ☐ Administration ☐ Support Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ☐ with symptoms ☐ without waiting for symptoms
Benadryl ordered: ☐ Yes ☐ No Give _________ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ☐ Yes ☐ No Special instructions: ______________________________

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: ______________________________

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Please note: Parents are responsible for planning & providing emergency medication for all activities outside of normal school hours.

Physician Signature: ____ Phone: ______________________

Written by: ____ Date: ______________________

☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: ______________________________

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

Campus/Grade __________ ID# ____________

Tuloso-Midway ISD

Health Services

Physician request for long-term administration of medication

This request is to be effective for the school year ____________

Physician fills out this area

Student's Name ________________________________ DOB __________________

Medication ____

Dosage Amount ____________ Route ______ Time to be administered ______________

Condition for which medicine is given ____

Inhalant Prescriptions

This student is both capable and responsible for self-administering this medication.

No_____ Yes – Supervised _____ Yes-Unsupervised _____

This student may carry this medication: No _____ Yes _____

Physician Signature ______________________________ Print Name _________________

Address ____

Phone Number ______________________________ Date of request _________________

I understand that a person who is not medically licensed may administer the medication and /or treatment. I understand that: (1)in accordance with Texas Education Code 21.905 medication is defined as: substances used to prevent, diagnose, cure, or relive signs and symptoms of disease; (2)there is no liability on the part of Tuloso-Midway ISD or it's employees for administration of medicine requested by the parent/guardian and for adverse reactions or side effects to the medication; (3)I agree to be responsible for maintaining an adequate supply of medications at the school to meet the child's needs; (4)this medication will be brought tot school only by a parent/guardian; (5)that my child will not be in possession of any medication at any time unless they have written permission from a physician stating they have a condition that requires immediate treatment; (6)this medication will be "properly labeled" as defined in the Tuloso-Midway ISD policy manual; (7)this medication will be destroyed if it is not picked up; (8)in accordance with the Nurse Practice Act, Texas Code, Section 217.11, the school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgment are not in the best interest of the student. I hereby authorize the exchange of medical information regarding my child's medication/treatment plan between the physician and Tuloso-Midway ISD Health Services Department. (9) Parents are responsible for planning & providing medication for all activities outside of normal school hours.

Parent fills out this area

Parent/Guardian Signature ______________________________ Date ________________

Home Phone: _____________ Work Phone: ___________ Cell Phone: ______________

Medication orders must be renewed by the attending physician and this release signed by the parent/guardian **annually.**

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