CELINA INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

Individualized Health Plan, Anaphylaxis

Student Name: _____ DOB: ____/____/____ Weight: _____lbs.

SEVERE ALLERGY TO:_____ Asthma: ☐ Yes ☐ No

TO BE COMPLETED BY THE PHYSICIAN: The parent/guardian of the above named student has notified the school that this student has a potentially life-threatening allergy and will require epinephrine at school, in the event of an emergency. Please complete this form based on your examination and knowledge of this student and sign in the spaces provided (multiple pages).

What type of exposure triggers this student's allergic reaction? ..... ☐ Ingestion ☐ Contact ☐ Inhalation ☐ Bite/Sting

OPTIONAL SECTION:
Extremely reactive to the following foods: _____
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion, sting/bite:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications. *
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort
OTHER:	_____

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert school nurse & parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

MEDICATIONS/DOSES

Epinephrine (brand and dose): _____
Antihistamine (brand and dose): _____
Other (e.g., inhaler-bronchodilator if asthmatic): _____
Location of above medications (in clinic unless permission to self-carry): _____
If able, this student has permission to self-administer the: **Epinephrine auto-injector:** ☐ Yes ☐ No **Inhaler:** ☐ Yes ☐ No

MONITORING
Stay with student; alert school nurse and parent. Tell EMS epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

Physician Signature: _____ **Date:**_____

Physician Name: _____ Phone: (____)_____-_____

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HEALTH SERVICES

1. Has this student been trained in the signs and symptoms of mild and anaphylactic reactions?
   - ☐ YES
   - ☐ NO
2. Is this student capable of self-administering the epinephrine auto-injector?
   - ☐ YES
   - ☐ NO
3. Has the student been trained in the self-administration of the epinephrine auto-injector?
   - ☐ YES
   - ☐ NO
4. Does this student need the supervision of a designated adult?
   - ☐ YES
   - ☐ NO
5. Does this student have physician permission to self-administer this medication & to carry it on himself/herself?
   - ☐ YES
   - ☐ NO
6. Does your child ride the bus to/from school?
   - ☐ YES (If yes, you will need to fill out a Transportation Health Form)
   - ☐ NO
7.
8. Does your child participate in any school-sponsored extracurricular activities/clubs?
   - ☐ YES
   - ☐ NO
   - ☐ If yes, please specify:
9. Please rate the level of understanding you feel your CHILD has regarding his/her allergy:
   - ☐ Knowing what he/she is allergic to
     - ☐ Minimal
     - ☐ Some
     - ☐ Good
   - ☐ Identifying items that might contain their allergen(s)
     - ☐ Minimal
     - ☐ Some
     - ☐ Good
   - ☐ Possible symptoms of a reaction (minor and severe)
     - ☐ Minimal
     - ☐ Some
     - ☐ Good
   - ☐ Do they know when to use antihistamine and/or inhaler vs. when to use epinephrine?
     - ☐ Minimal
     - ☐ Some
     - ☐ Good

Note: If specific food substitutions are required for your child in the school cafeteria, please contact the food services department and fill out a food allergy form. The parent/guardian is responsible for working with the campus administrator, school nurse, and classroom teacher regarding food during snack times, class parties, and/or field trips. CISD cannot guarantee that foods brought from an outside source have been made without allergen products/or contact with these products. The Texas *Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis* is available online for reference.

I, the undersigned, parent/guardian of _____ request that an epinephrine auto-injector be administered to my child as prescribed by the physician. I understand that while the school campus maintains a limited supply of unassigned epinephrine for individuals experiencing symptoms of anaphylaxis, it is my responsibility as the parent/guardian to provide the prescribed medications for my child to the school for the treatment prescribed by my physician above to be provided by district personnel, especially during off-campus activities where unassigned epinephrine is not available. The school administration will designate trained staff to perform this procedure. It is my understanding that in the performance of the procedure, the designated person(s) will be using the standardized procedure per the directions of the epinephrine injector manufacturer, which the physician has approved. I understand that in addition to this form, a CISD Medication Administration Request form must be completed for each medication provided to the school for my child, following CISD medication guidelines. I will notify the school immediately if my child's health status changes, I change physicians, or the procedure is canceled or changed in any way. I allow appropriate school staff to contact the physician/healthcare provider listed above for additional information about my child's allergy and/or prescribed treatment as needed and consent to releasing those allergy-related medical/health records.

My child and I have discussed and agreed that my child will promptly alert CISD staff regarding symptoms and treatment so that appropriate follow-up care can be provided while in the school setting. I understand that the school administration will designate trained staff to monitor the procedure (as made aware of signs/symptoms by the student). I understand that in performing this procedure, my child will be using the standardized procedure per the epinephrine injector manufacturer's directions, which the physician has approved. I understand that CISD reserves the right to require that this medication be kept in the clinic if, in the school nurse's judgment, my child cannot or will not safely carry the medication and properly self-administer the medication.

Parent's Signature: _____ Date: _____

RN Review (signature): _____ Date: _____