

Place
Child's
Picture
Here



Katy Independent School District
Health Services Department
Allergy Action Plan

Transportation
☐ Car Rider ☐ Walker
☐ Bus # _____
☐ Other: _____

Student has permission to transport
medication listed below to and from
school?
☐ YES ☐ NO

Students Name		Date of Birth	Grade
Parent/Guardian	Phone		Cell
Other Emergency Contact	Phone		Cell
Allergy to:		Triggers:	

Asthma: ☐ Yes ☐ No *Higher risk for severe reaction

Sensitivity: ☐ Ingestion Only ☐ Topical/Ingestion ☐ Topical ☐ Airborne

Additional Details:	Yes	No	Comments
History of EpiPen use			
History of reaction			
Special lunch seating required			
Classroom accommodation needed			

STEP 1: TREATMENT

Symptoms:		<u>Give Checked Medication**:</u> ** (To be determined by physician)	
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart†	Weak or thready pulse, low blood pressure, fainting, pale,	☐ Epinephrine	☐ Antihistamine
• Other†	_____	☐ Epinephrine	☐ Antihistamine
•	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

	Name of Medication	Dose	Route
Antihistamine			
Epinephrine			
Other			
Other			

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: ANAPHYLACTIC EMERGENCY PROTOCOL

• Contact campus nurse at _____
• Administer emergency medications
• Call 911
• Notify parent or emergency contact
• Document episode/Student Accident Report Filed & complete Post Anaphylaxis Reaction Review
• Other: _____

I agree with the recommendations of my child's HCP and authorize Katy ISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate Katy ISD employees for the current school year. I am aware that Food and Nutrition Services will not be notified of my child's allergies unless a Diet Modification form has been completed by my child's physician and has been submitted to the campus nurse.

Physician Signature:	Printed Name:	Phone:	Date:
Parent Signature:	Printed Name:	Phone:	Date:

ADDENDUM to Action Plan**NURSE USE ONLY:**

- ☐ Transportation Notified: Date Faxed _____
- ☐ Bus Driver Notified
- ☐ Added to Medical Alerts
- ☐ Self-Carry
- ☐ Diet Modification: Date Faxed _____
- ☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◇ TRAINED STAFF MEMBERS ◇

(To be completed by campus personnel)

Teacher's Name:	Date:
Teacher's Name:	Date:
Administrator's Name:	Date:
Office Staff's Name:	Date:
Cafeteria Staff's Name:	Date:
Bus Driver's Name:	Date:
Other Name:	Date:
Other Name:	Date:
Other Name:	Date:

OTHER COMMENTS:

Nurse Signature: _____

Date: _____