



WFISD Health Services Department

3106 Borton St, Wichita Falls, TX 76306 | 940-235-1033

Severe Allergy Management: Parent Checklist

Welcome & Safety Instructions

Dear Parent/Guardian,

Our primary goal is to ensure a safe, inclusive, and healthy learning environment for your child. In accordance with Texas Education Code guidelines, managing a life-threatening allergy requires close collaboration between home and school. Please review and complete the checklist below before your child begins the school year. All medical forms and medications must be hand-delivered to the campus clinic by an adult; students may not transport medications unless explicitly authorized for self-carry.

Checklist

- ☐ Notice of Medical Disclosure/Consent Form 499-042 (Sign by parent/guardian)
- ☐ Family Food Allergy Health History Form 499-039 (Sign by parent/guardian)
- ☐ Emergency Action Plan (Signed by physician and parent/guardian)
- ☐ Dietary Accommodation Form (Only if requesting school cafeteria meal modifications/restrictions)
- ☐ Medication Administration Request Form 499-131 (Signed by physician and parent/guardian)
 - ☐ Epinephrine Auto Injector (Unopened, unexpired, with pharmacy label attached)
 - ☐ Medication Self Carry Agreement Form 499-131-A (Only if student will self-carry. Signed by physician and parent/guardian)

Helpful Reminders & Tips

- Schedule a brief meeting with the campus nurse to review documents and finalize your child's Individualized Healthcare Plan (IHP)
- Provide a safe classroom snack for your child for those unexpected parties or events.
- Review symptoms and safety rules with your child. Reinforce key rules such as never sharing or trading food, notifying and seeking help from an adult immediately should a reaction occur.
- Set a reminder to replace epinephrine before they expire.
- Update contact information immediately if numbers or emergency contacts change.
- Provide updates to the campus nurse immediately after medical visits if medication or dosage changed. Remember for any medication changes a new medication order is required.

We appreciate your help in our effort to provide the best care for your child



WFISD Health Services Department

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Student Picture

Notice of Medical Disclosure & Documentation of Severe Allergy

Student Full Name _____ DOB _____

Campus Name _____ Grade _____

Severe Allergen(s): _____

Legal Acknowledgements and Information Sharing

(Parent/Guardian initial each box to confirm your understanding and agreement)

[☐] **INFORMATION DISSEMINATION TO STAFF:** I understand and agree that a copy of this Notice of Disclosure and the attached Emergency Action Plan will be distributed to campus personnel with a direct "need-to-know." This includes, but is not limited to classroom teachers, substitute teachers, cafeteria managers, physical education coaches, and bus drivers.

[☐] **SELF-CARRY AUTHORIZATION (TEC § 38.0151):** *(Check if applicable)*

[☐] My child is authorized to self-carry and self-administer their rescue medication. I confirm that a Physician's Self-Carry Authorization form is on file in the school clinic.

If self-carry authorization form checked nurse to verify and initial _____

Classroom Teacher Verification

(Campus Nurse to fill out)

⚠ NOTICE TO STAFF / SUBSTITUTES: The Emergency Action Plan for this student is securely attached to this disclosure sheet. You must review the specific triggers, medical history, and protocol immediately upon receiving this file.

Primary Location of Student Medication:

[☐] School Clinic

[☐] On Student's Person (Self-Carry Backpack/Pocket)

[☐] Specified Location: _____

Mandatory Signatures

Parent/Guardian

Date

Nurse

Date



Family Food Allergy Health History Form



Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ☐ No ☐ Yes

2. History and Current Status

a. What is your child allergic to? <table><tr><td>☐ Peanuts</td><td>☐ Insect Stings</td></tr><tr><td>☐ Eggs</td><td>☐ Fish/Shellfish</td></tr><tr><td>☐ Milk</td><td>☐ Chemicals _____</td></tr><tr><td>☐ Latex</td><td>☐ Vapors _____</td></tr><tr><td>☐ Soy</td><td>☐ Tree Nuts (walnuts, pecans, etc.)</td></tr><tr><td>☐ Other: _____</td><td></td></tr></table>	☐ Peanuts	☐ Insect Stings	☐ Eggs	☐ Fish/Shellfish	☐ Milk	☐ Chemicals _____	☐ Latex	☐ Vapors _____	☐ Soy	☐ Tree Nuts (walnuts, pecans, etc.)	☐ Other: _____		b. Age of student when allergy first discovered: _____ c. How many times has student had a reaction? ☐ Never ☐ Once ☐ More than once, explain: _____ d. Explain their past reaction(s): _____ e. Symptoms: _____ f. Are the food allergy reactions: ☐ Same ☐ Better ☐ Worse
☐ Peanuts	☐ Insect Stings												
☐ Eggs	☐ Fish/Shellfish												
☐ Milk	☐ Chemicals _____												
☐ Latex	☐ Vapors _____												
☐ Soy	☐ Tree Nuts (walnuts, pecans, etc.)												
☐ Other: _____													

3. Trigger and Symptoms

- a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
- b. How does your child communicate his/her symptoms? _____
- c. How quickly do symptoms appear after exposure to food(s)? _____ secs. _____ mins. _____ hrs. _____ days
- d. Please check the symptoms that your child has experienced in the past:
- | | | | | | |
|-------------------|--|---|-------------------------------------|-----------------------------------|---|
| Skin: | ☐ Hives | ☐ Itching | ☐ Rash | ☐ Flushing | ☐ Swelling (face, arms, hands, legs) |
| Mouth: | ☐ Itching | ☐ Swelling (lips, tongue, mouth) | | | |
| Abdominal: | ☐ Nausea | ☐ Cramps | ☐ Vomiting | ☐ Diarrhea | |
| Throat: | ☐ Itching | ☐ Tightness | ☐ Hoarseness | ☐ Cough | |
| Lungs: | ☐ Shortness of breath | ☐ Repetitive Cough | | ☐ Wheezing | |
| Heart: | ☐ Weak pulse | ☐ Loss of consciousness | | | |

4. Treatment

- a. How have past reactions been treated? _____
- b. How effective was the student's response to treatment? _____
- c. Was there an emergency room visit? ☐ No ☐ Yes, explain: _____
- d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____
- e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____
- f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes
- g. Have you used the treatment or medication? ☐ No ☐ Yes
- h. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. Self Care

- | | | |
|---|-----------------------------|------------------------------------|
| a. Is your student able to monitor and prevent their own exposures? | ☐ No | ☐ Yes |
| b. Does your student: | | |
| 1. Know what foods to avoid | ☐ No | ☐ Yes |
| 2. Ask about food ingredients | ☐ No | ☐ Yes |
| 3. Read and understands food labels | ☐ No | ☐ Yes |
| 4. Tell an adult immediately after an exposure | ☐ No | ☐ Yes |
| 5. Wear a medical alert bracelet, necklace, watchband | ☐ No | ☐ Yes |
| 6. Tell peers and adults about the allergy | ☐ No | ☐ Yes |
| 7. Firmly refuses a problem food | ☐ No | ☐ Yes |
| c. Does your child know how to use emergency medication? | ☐ No | ☐ Yes _____ |
| d. Has your child ever administered their own emergency medication? | ☐ No | ☐ Yes _____ |

6. Family / Home

- | | |
|--|--|
| a. How do you feel that the whole family is coping with your student's food allergy? | _____ |
| b. Does your child carry epinephrine in the event of a reaction? | ☐ No ☐ Yes |
| c. Has your child ever needed to administer that epinephrine? | ☐ No ☐ Yes |
| d. Do you feel that your child needs assistance in coping with his/her food allergy? | _____ |

7. General Health

- | | |
|--|--|
| a. How is your child's general health other than having a food allergy? | _____ |
| b. Does your child have other health conditions? | _____ |
| c. Hospitalizations? | _____ |
| d. Does your child have a history of asthma? | ☐ No ☐ Yes |
| If yes, does he/she have an Asthma Action Plan? | ☐ No ☐ Yes |
| e. Please add anything else you would like the school to know about your child's health: | _____
_____ |

8. Notes:

Parent / Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

History of anaphylaxis: ☐ Yes ☐ No

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



1. **ADMINISTER EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve.

ADDITIONAL PHYSICIAN COMMENTS

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE AND CALL 911.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine and call 911.

☐ If this box is checked by the child's physician, the child has an extremely severe allergy to _____ and should be given epinephrine at the first sign of any symptoms, even if mild.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM

☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

☐ Patient may self-carry ☐ Patient may self-administer

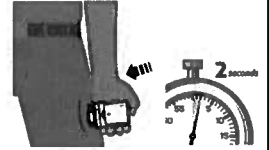
**FARE**

Food Allergy Research & Education

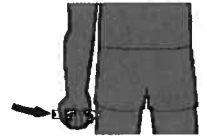
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

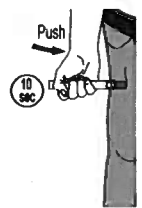
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

**HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS**

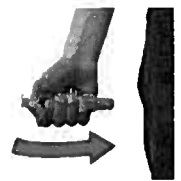
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

**HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS**

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

**HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES**

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

**ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:**

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

PLEASE READ

Guidelines

1. The bottom portion of form **must be filled out** and **signed** by student's medical authority, such as **licensed physician, physician assistant, nurse practitioner, allergist, or a clinical registered dietitian** when requesting a special diet accommodations.
2. Completed forms needs to be faxed to Farai Sithole.
Fax number is 940-235-1066. Completed forms may also be given to the school nurse. Once received, a modified menu will be developed.
3. If dietary restrictions need to be **changed** or **stopped** during the school year, a new form must be submitted.
4. Parent/guardians are **responsible** to notify Farai Sithole if student changes schools or has a change in their dietary restrictions.
5. Farai Sithole or regional dietitian has the right to contact physician office to ask questions and/or clarify information on special diet form.
6. Please email Farai Sithole for a **new** or **replacement form** at **fsithole@wfisd.net**

Farai Sithole
Resident District Manager
Email: fsithole@wfisd.net
Phone: 940-235-1065 x 29002
Fax: 940-235-1066



Child Nutrition Special Diet Form 2026-2027

Parents/Guardians, please fill in the information below in print.

Student Name:

School:

Grade:

Your name:

Email:

Phone:

Which meals will student eat from the cafeteria? **Choose one:**

- ☐ Breakfast & Lunch ☐ Breakfast Only ☐ Lunch Only ☐ None, breakfast and lunch will be from home.

Which accommodation is needed? **Choose one:**

- ☐ My child needs special diet accommodations. **(Required to have medical authority signature)**
- ☐ My child needs the same dietary accommodations as received previous school year(s). **(Medical authority signature NOT required)**
- ☐ My child no longer needs dietary accommodations and is allowed to receive a regular meal. **(Medical authority signature NOT required)**

Parent/Guardian Signature: _____ Date: _____

Information Below is to be Completed by a Physician

Food Allergy/Intolerance:

• Dairy: **Choose One**

- ☐ Liquid milk (other forms such as yogurt and cheese are okay) **or**
- ☐ Liquid milk, yogurt, and cheese (dairy as an ingredient, such as breads/baked goods, is okay) **or**
- ☐ Dairy products in ALL foods, including liquid milk, dairy, yogurt, cheese, and as an ingredient in other foods.

• Eggs: **Choose One**

- ☐ Whole Eggs (eggs as an ingredient in other foods are okay) **or**
- ☐ Eggs in all forms (including as an ingredient in other foods)

• Other:

- ☐ Peanuts ☐ Treenuts ☐ Soy ☐ Other (please specify) _____
- ☐ Fish ☐ Shellfish ☐ Wheat/Gluten ☐ Sesame Seed

Milk substitution ☐ Lactose-free milk ☐ Soy Milk ☐ Water

Food substitution _____

What kind of contract will cause a reaction? ☐ Airborne ☐ Trace Cross-Contact ☐ Ingestion

Patient's food allergy/intolerance is: ☐ Non-Life Threatening ☐ Life Threatening (Anaphylaxis)

Other Dietary Restrictions/Needs

- Texture Modification: ☐ Soft ☐ Chopped ☐ Pureed ☐ Liquids Only
- Thickened Liquids: ☐ Nectar ☐ Honey ☐ Pudding
- Diabetic/Carb Restriction:

- Sodium Restriction:

Physician Signature: _____

Date: _____

Farai Sithole

Resident District Manager

Email: fsithole@wfid.net

Phone: 940-235-1065 x 29002

Fax: 940-235-1066





Medication Administration Request School Year 2026-2027

Student's Name _____ GRADE _____ DOB _____ ID# _____

Medication Allergies: ☐ None _____

ORIGINAL PRESCRIPTION (HOME ORDER)

Statement: This section reflects the original provider prescription as dispensed by the pharmacy.

Medication Name (as on pharmacy label): _____

Dosage: _____ Route: _____ Time: _____

SCHOOL ADMINISTRATION ORDER FOR SCHEDULED MEDICATIONS

Statement: This section is what the school nurse will administer during school hours for the above medication.

Dosage: _____ Route: _____ Time: _____

☐ after lunch

Inhalers ☐ Prior to physical activity

Indication reasons/diagnoses: _____

Start Date: _____ End Date: _____

Is the above order an emergency rescue medication? ☐ Yes ☐ No

Is the student capable and allowed to self-carry? ☐ Yes ☐ No

If YES, fill out the medication self-carry agreement form 499-131-A

☐ Medication is also scheduled PRN. Minimum time between doses _____

P
H
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N

FOR OVER THE COUNTER MEDICATIONS

Medication Name: _____

☐ OTC medications are to be administered per manufacturer's labeled directions unless otherwise directed below.

Dosage: _____ Route: _____ Time: _____

Indication (reason): _____

Special Instructions / Parameters: _____

Start Date: _____ End Date: _____

PROVIDER ACKNOWLEDGEMENT

I acknowledge that the school administration schedule may differ from the pharmacy label (original home orders) and is medically appropriate for this student during school hours.

Physician's Signature: _____ Date: _____

Name Printed: _____ Name of Office: _____

Phone: _____ Fax: _____

PARENT

☐ I acknowledge that I have read, understood, and signed the Medication Policy

Parent/Legal Guardian Name: _____

Signature: _____ **Date:** _____

Phone Number: _____

SCHOOL NURSE VERIFICATION

- Comments:** _____

Nurse Signature who accepted the order/medication: _____ Date: _____

Medication/Procedure Order Reviewed by Supervising RN: _____ Date: _____

Document witnessed pill count of medication received, returned to parent, or intra-district transfer to new campus.

Count at both sending and receiving campus. Witness: parent/guardian or WFISD staff.

[illegible]

Wichita Falls ISD
MEDICATION SELF-CARRY AGREEMENT

This plan is in accordance with new legislation, HB 1688, which passed during the 2001 Texas Legislative Session. This bill allows students to carry and self-administer emergency rescue medication while at school or school functions with permission from parents, physician, and school nurse.

Student's Name: _____ Grade: _____ DOB: _____

Parent/Guardian

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Physician student see for allergies/asthma: _____ Phone: _____

SELF-ADMINISTRATION OF EMERGENCY RESCUE MEDICATION

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY STATE OF TEXAS

- ☐ I have instructed _____ (student's name) in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the following emergency rescue medication while on school property or at school-related events:

Emergency rescue medication (Quick-relief medication):

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

For asthma inhalers only Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

Call 911 or EMS if minimal or no improvement.

Medication is prescribed for the time period _____ until _____ (current school year maximum).

- ☐ It is my professional opinion that _____ (student's name) should **NOT** be allowed to carry and self-administer any of his/her emergency rescue medication while on school property or at school related events.

Physician's Signature

Date

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her emergency rescue medication while on school property or at school-related events according to school district policy and the student agreement below.

Parent/Guardian's Signature

Date

C. TO BE COMPLETED BY STUDENT and SCHOOL NURSE

____ Student knows name, correct dosage, purpose, expected effects, and side effects of medication.

____ Student demonstrates correct use/administration of medication.

____ Student understands that medication must have prescription label affixed, that authorization from school nurse must be carried, that allowing anyone else to use this medication will result in disciplinary action, and that the **PRIVILEGE** of carrying this medication can be rescinded for violating any part of this agreement.

Student's Signature

School Nurse's Signature

Date

For OFFICE use only: ☐ Med entered in EMR ☐ Scanned and uploaded ☐ Updated Health Condition ☐ Update/create IHP

