FOOD ALLERGY PLAN

The HISD Food Allergy Plan addresses any student who has a potentially severe food allergy which may require treatment at school. The forms, listed below, will give us the necessary information and authorization to treat your child in an emergency.

1. Food Allergy Action Plan – Should be on file for every student with a severe allergy. Must be updated and signed by the doctor every school year.
2. Medication/Treatment Request – One should be used for each medication sent to school.
3. Individual Care Plan.
4. Statement Regarding Meal Substitutions or Modifications.

The student's supplies should include: Epi-pen with prescription label on it and antihistamine (such as Benadryl), if your child's plan calls for it. Please be alert to the expiration dates on these medications.

If HISD does not have these forms and supplies on hand and your child has a serious reaction, we may need to call 911 to assure your child's safety.

It is important for your child's safety that we have the proper authorizations and supplies on hand in order to respond to an emergency. We appreciate your help in our effort to provide the best care for your child.

Food Allergy Action Plan

Emergency Care Plan

Name: _____ **D.O.B.:** __/__/__

Allergy to: _____

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

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:

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, diarrhea, 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

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and 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): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad 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. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

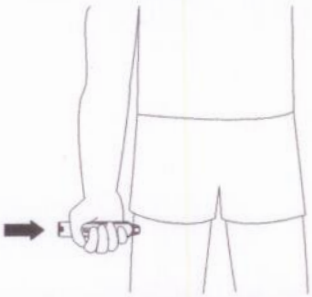
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER **Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011**

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

HENRIETTA ISD

Department of School Health Services

Prescription Medication / Treatment Request

When it is necessary for your child to receive medication during the school day:

- Parents/guardians should deliver the medication/treatment supplies to the clinic or office along with the completed and signed medication/treatment form.
- Medication must be in a bottle from the pharmacy, properly labeled with the student's name, the physician, the medication name and quantity, administration directions with dosage and time and the date of this prescription's issue. *You may ask your pharmacist for a second, properly labeled bottle so you have one for home and one for school.*
- Medications sent in baggies or unlabeled containers, will not be given. Medication will not be accepted if the label has been altered by hand.
- The Prescription Medication Request must be completed each school year and when there are any changes to the original request including a medication and/or dose change. A separate form must be completed for each medication.
- Parents/guardians are strongly encouraged to pick up all medication immediately after it is discontinued. At the End Of The School Year, All Medication That Has Not Been Picked Up By The Parent/Guardian Will Be Destroyed.

PARENT

Student:_____ Birthdate:_____ Grade:_____

School:_____ Medication/Food Allergies: _____

My signature below indicates that I request HISD staff (may include trained Non-Medical personnel) to administer the medication specified below to my child, and I am giving permission for HISD staff to contact the physician for additional information, if needed. I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose information to those within the school district who have a need to know for legitimate educational purposes.

Parent Signature:_____ Email Address: _____

Phone (Home):_____ (Work):_____ (Cell): _____

PHYSICIAN

Medication/Treatment:_____

Dosage:_____ Route:_____ Time:_____

Special Instructions/Precautions/Side Effects of this medication: _____

Condition for which medication is required:_____ Termination Date of Medication: _____

Physician's Signature:_____ Date: _____

Phone:_____ Fax:_____

IF THE ORDERED MEDICATION IS AN INHALER OR AN EPI PEN, PLEASE ANSWER THE FOLLOWING:

1. May this student carry an INHALER / EPI-PEN on self during the day? ❒ Yes ❒ No
2. Has the student been instructed in the use of the INHALER / EPI PEN? ❒ Yes ❒ No
3. Is the student able to self-administer the INHALER / EPI PEN? ❒ Yes ❒ No

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

Henrietta Independent School District
Non-Prescription Medication Authorization

Date of Request_____

Name of Student:_____Birthdate:_____

School:_____Grade_____

Home Phone:_____Emergency Phone:_____

Medication Allergies:_____

Food/Environmental Allergies:_____

Date medication is to be discontinued:_____

Medication must be in an original properly labeled container

Name of medication _____
Amount to be given (must agree with package directions, otherwise a physician's order is required):_____

Frequency of Administration (Must agree with package directions, otherwise a physician's order is required):_____

I request this medication to be given to my child during school hours. I fully understand that trained NON-MEDICAL District personnel may administer the medication. I understand that the School District, the Board, and it's employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medicine to a student, provided such administration conforms to the requirements of this policy.

_____ _____

Signature of parent/guardian Day time phone number

Henrietta Independent School District

Epi-Pen / Epinephrine Individualized Care Plan

Student: _____ DOB_____ Grade_____

Diagnosis: _____

Sensitivity To: _____

Potential for: _____

Signs and Symptoms of Severe Anaphylaxis:

Mouth- itching, swelling of lips and/or tongue Throat- itching, tightness/closure, hoarseness

Skin- itching, hives, redness, swelling Gut- vomiting, diarrhea, cramps

Lung- shortness of breath, cough, wheeze Heart- weak pulse, dizziness, passing out

Instructions will be provided to designated school staff. School nurse is not on school campus at all times.
Trained Staff: _____

*** Student has been taught how and when to use epinephrine auto-injector: (circle) Yes or No

1. Someone needs to stay with the student. Another staff member will get Epi-Pen from the unlocked, labeled clinic cabinet or other designated area, such as classroom or cafeteria.
   Person staying with student needs to provide reassurance and observe for respiratory difficulty.
   Closely observe airway for difficulty breathing and provide CPR if needed.
   The following are knowledgeable of CPR: _____
   _____

2. Give Epi-Pen / Epinephrine (dosage) _____
   Method of administration: _____ Time administered: _____
   Site of injection: _____ as prescribed by _____. Monitor for side-effects such as increased pulse, flushing of the skin, "feeling jittery", lightheaded, weakness, nausea and headache.)
3. Call 911, parents/guardian.
4. Dispose of used injection in red sharps container.
5. Someone must stay with student to observe respiratory functions until ambulance arrives. Closely observe airway for difficulty breathing and provide CPR if needed.
6. When ambulance arrives, send labeled Epi-Pen/Epinephrine box so ER doctor will know what medication and what dose was given.

_____ _____
Physician/Healthcare Provider Signature Date

_____ _____
Parent/Guardian Signature Date

Henrietta ISD Health Services
Physician Authorization for Diet Modifications

Campus: 20__-20__

The U.S. Department of Agriculture School Meals Program requires that your child's physician answer all questions in order for any diet modifications to be made in school meals.

STUDENT	**DOB**	**CAMPUS/GRADE/HR**

List any disability/diagnosis requiring meal modification	
Life-threatening food allergy if applicable: (check foods to omit)	☐fluid milk ☐peanuts ☐tree nuts ☐eggs ☐fish ☐shellfish ☐wheat ☐soy ☐other, specify:_____
Can the student consume foods where the allergen is an ingredient in the food product/recipe?	☐yes ☐no Explain:
Foods not allowed(specify):	
Major life activity affected by the disability, if applicable	☐learning ☐performing manual tasks ☐speaking ☐breathing ☐hearing ☐seeing ☐other, specify: _____
Other instructions:	

Physician (print name)	Phone
Physician Signature	Date

Please return completed form to the campus nurse or fax to :

Brittanie Brown, HISD Food Services Director

940.538.7515

Reviewed 8/13/cs