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. 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.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ____________________ D.O.B.: ____________

Allergy to: ____________________

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

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

Extremely reactive to the following allergens: ____________________

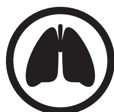
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

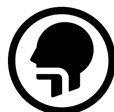
FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

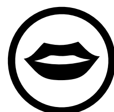


LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

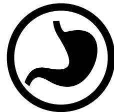


THROAT
Tight or hoarse throat, trouble breathing or swallowing

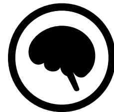


MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



OTHER
Feeling something bad is about to happen, anxiety, confusion

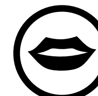
OR A COMBINATION of symptoms from different body areas.

1. **INJECT 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. Patient should remain in ER for at least 4 hours because symptoms may return.

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.

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.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ____________________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____________________

Antihistamine Dose: ____________________

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

____

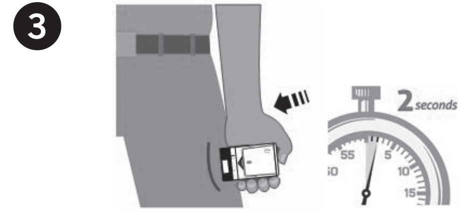
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

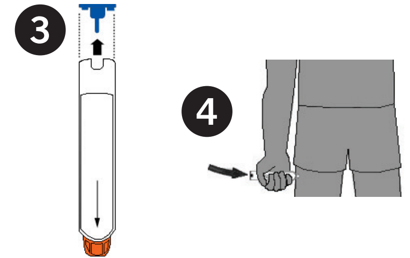
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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



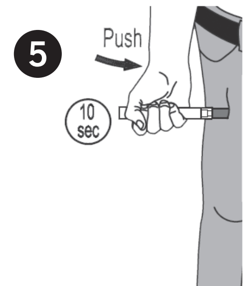
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



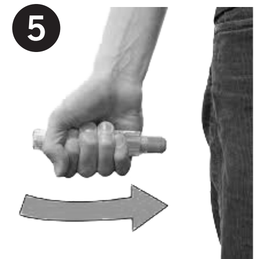
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. 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.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. 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.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

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: ____________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

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 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