



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.

**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: _____

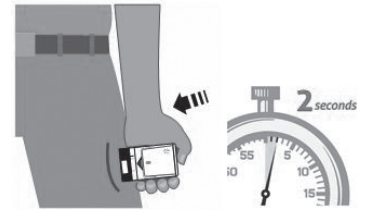
Antihistamine Dose: _____

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

HOW TO USE AUVI-Q® (EPINEPHRINE 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.

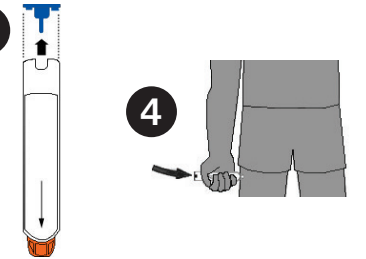
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HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.

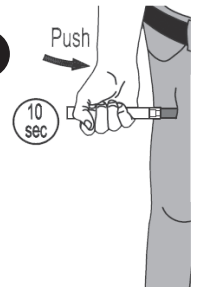
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HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

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.

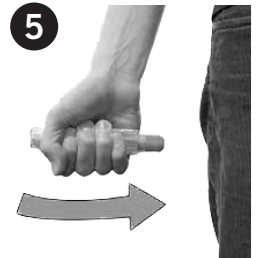
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HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

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.

5



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: _____

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.**

P A R E N T	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): _____
P H Y S I C I A N	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has the student been instructed in the use of the INHALER / EPI PEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is the student able to self-administer the INHALER /EPI PEN? <input type="checkbox"/> Yes <input type="checkbox"/> 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

- 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: _____

- 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.)

- Call 911, parents/guardian.
- Dispose of used injection in red sharps container.
- Someone must stay with student to observe respiratory functions until ambulance arrives. Closely observe airway for difficulty breathing and provide CPR if needed.
- 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)	<input type="checkbox"/> fluid milk <input type="checkbox"/> peanuts <input type="checkbox"/> tree nuts <input type="checkbox"/> eggs <input type="checkbox"/> fish <input type="checkbox"/> shellfish <input type="checkbox"/> wheat <input type="checkbox"/> soy <input type="checkbox"/> other, specify: _____	
Can the student consume foods where the allergen is an ingredient in the food product/recipe?	<input type="checkbox"/> yes <input type="checkbox"/> no Explain: _____	
Foods not allowed(specify):		
Major life activity affected by the disability, if applicable	<input type="checkbox"/> learning <input type="checkbox"/> performing manual tasks <input type="checkbox"/> speaking <input type="checkbox"/> breathing <input type="checkbox"/> hearing <input type="checkbox"/> seeing <input type="checkbox"/> other, specify: _____	
Other instructions:		

Physician (print name)	Phone
Physician Signature	Date

<p>Please return completed form to the campus nurse or fax to : Brittanie Brown, HISD Food Services Director 940.538.7515</p>
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