Campus: _____ School Year: _____

Academy ISD Health Services Parent Authorization for Severe Allergy Emergency Plan

Student	DOB	Grade/Homeroom	Rides Bus #

Allergic to:	**Severely** allergic to the following **food**:

☐No ☐Yes Student has asthma (higher risk for allergic reaction)
☐No ☐Yes Student has had a reaction that requires the use of Epinephrine
☐No ☐Yes Student is permitted to carry & self-administer their Epinephrine (Epi-pen, Auvi-Q, other)
☐No ☐Yes Student understands how to avoid allergen/food
☐No ☐Yes Student knows when & how to tell an adult they may be having an allergy-related problem

Questions related to severe food allergy:

☐No ☐Yes Give Epinephrine immediately for **ANY symptoms** if allergen was likely eaten
☐No ☐Yes Give Epinephrine immediately if the allergen was **definitely eaten, even if NO symptoms noted**
☐No ☐Yes Student requires a special diet modification

Emergency medication required at school: **Name/Dosage/Route/Times**	Pharmacy/RX #	Expiration Date
Emergency medication required at school: **Name/Dosage/Route/Times**	Pharmacy/RX #	Expiration Date

Medication will be kept at school:
☐ N/A ☐ In health office ☐Student will carry in/on_____ Other_____

Please review standard emergency care at school and ADD ADDITIONAL INSTRUCTIONS as needed

If you see one or more of the following potentially LIFE-THREATENING symptoms:	DO THIS:
• **Lungs:** short of breath, wheezing, repetitive cough • **Heart:** pale, blue, faint, weak pulse, dizzy, confused • **Throat:** tight, hoarse, trouble breathing/swallowing • **Mouth:** obstructive swelling (tongue and/or lips) • **Skin:** hives, itchy rashes, swelling (eyes, lips, etc) • **Gut:** vomiting, diarrhea, cramping, abdominal pain **OR if you see a combination of symptoms from different body areas:** • **Skin:** hives, itchy rashes, swelling (eyes, lips, etc) • **Gut:** vomiting, diarrhea, cramping, abdominal pain	☐ **Immediately inject Epinephrine _____ (dose).** [Note time epi was given] 1. **Call 911**. Inform operator epi was given. CONTACT NURSE OR PRINCIPAL, CONTACT PARENTS. Treat student even if parents cannot be reached. 2. Stay with student and monitor. For a severe reaction, consider keeping student lying on back with legs raised. ☐ A 2nd dose of Epinephrine can be given 5 minutes or more after the 1st symptoms persist or recur. 3. If ordered, give additional medication: ☐ Antihistamine** _____ **(name/dose)** ☐ If asthmatic, give inhaler: _____ 4. If ordered, give additional medication:

Actions to Take for MILD Allergic Reaction

If you see:	Do this:
• Mouth: itchy mouth • Skin: few hives around face/mouth, mild itch • Gut: mild nausea/discomfort **The severity of symptoms can quickly change**	☐ **Antihistamine** _____ (name/dose)** 1. Stay with student 2. Notify school nurse/principal and parent that a suspected allergic reaction has occurred 3. If symptoms become more severe, use epinephrine as instructed **IMPORTANT: Asthma inhalers and antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Other instructions/plans to avoid allergen:

Physician/Parental authorization for SEVERE ALLERGY EMERGENCY PLAN

☐Yes ☐No The above-named student has a severe allergy and is capable of possession and self-administration of prescribed allergy medication(s) while at school and school-related events.

Authorizing Physician: (print)	Physician signature:	Date:
Additional Comments:	Physician Phone:	

PARENT SIGNATURE/AUTHORIZATION REQUIRED (ON BACK OF THIS FORM) → → →

I grant permission to Academy ISD to administer this medication to my child. I am giving permission to AISD staff to contact my physician for additional information as necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his/her health condition(s). I understand that a medically untrained designee of the principal may give the medication. I understand that, per Texas Education Codes 38.015 & 22.052, it is my responsibility to submit a parent/guardian-signed medication administration form [a separate, additional document] and a physician/provider signed statement permitting the student to self-carry [if physician does not authorize & sign this form].

☐ **I request that my child be permitted to carry their allergy medication on their person in school/at school-related events/activities and to use it as indicated.**

Parental authorization: (print & sign)		Date:
Parent Email:	Best emergency phone:	Other phone:
Emergency Contact:	Phone:	Other phone:

SCHOOL USE ONLY (below this line)

Received By: (print & sign)	Date:	Teachers notified		Rides Bus #
Campus Nurse: (print & sign) I have reviewed and understand this form. I feel competent to execute this Allergy Emergency Plan.		☐ RN ☐ LVN ☐ other	Initial	Date:
Supervising RN: (print & sign) I have reviewed this form and delegate the execution of this Allergy Emergency Plan to the above-named individual.			Initial	Date:

CAMPUS NURSES: if medication is indicated, you MUST have a medication administration form SIGNED BY GUARDIAN prior to administration. Document administration of medication on BOTH the form and the Electronic Health Record. Update yearly. _____ initial _____ initial

Staff Notes

(document parent contact, clarification, indicate additional forms, etc.)