Malakoff High School

15201 FM 3062 Malakoff, TX 75148
(903) 489-1527 fax (903) 489-0971

Dear Parent,
Our records indicate that your child ____________________________
has a potentially severe allergy that may require treatment at school. Attached to this letter are the forms, listed below, that will give us the necessary information and authorization to treat your child in an emergency.

1. Allergy/Anaphylaxis Physician's Orders – should be completed by parent and physician appropriately and on file for every student with a severe allergy. Must be updated and signed by the doctor every school year.
2. Food Allergy Action Plan – Should be on file for every student with a severe allergy. Must be updated every school year.
3. Medication Request Form (2) – One should be used for each medication sent to school. In the event a student keeps an Epi-Pen with them, must have a note from the doctor stating the student can keep the Epi-Pen with them at all times.

Your child'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.

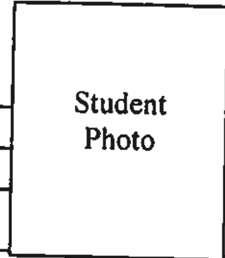
If we do not have these forms and supplies on hand and your child has a serious reaction, we may need to call 911 to assure your child's safety. Unfortunately, the cost is billed to the parent.

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

Thank you,

Deborah Vieregge, RN
Malakoff High School/District Nurse

STUDENT ALLERGY/ANAPHYLAXIS CARE PLAN



Student Name ____________________ D.O.B. ________ Teacher __________
School Nurse ____________________________ Phone Number __________
Health Care Provider ____________________ Preferred Hospital __________
History of Asthma ☐ No ☐ Yes (Higher risk for severe reaction)

ALLERGY: (check appropriate) **TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY***

☐ **Foods (list):**
☐ **Medications (list)**
☐ **Latex:** ***Circle***: **Type I (anaphylaxis)** **Type IV (contact dermatitis)**
☐ **Stinging Insects (list):**
☐ **Other (list):**

RECOGNITION AND TREATMENT: **To be completed by Health Care Provider *ONLY***		**Give CHECKED Medication**	
If food ingested or contact with allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), **GIVE:**			
The severity of symptoms can quickly change. + Potentially life-threatening			

DOSAGE: **TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY***

- **Epinephrine:** Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
- **Antihistamine: Diphenhydramine (Benadryl®)** _____ mg (Liquid or Fastmelts). ONLY *if able to swallow.*
- **Epinephrine Auto Injector will be used for a severe asthma episode at school, this may be given in addition to the student's prescribed medication or if the student does not have access to their prescribed medication.**
- ☐ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.

☐ It is my professional opinion that this student **SHOULD NOT** carry the auto-injector.
☐ This child has special needs and the following instructions apply: ______________________
____.

Health Care Provider Signature ____________________ Phone: ______________ Date __________

ASD EMERGENCY PROTOCOL:

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.

Rev 7/09
Form adapted from the Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, Alaska Chapter

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Care Plan (continued) Student Name ____________________ **D.O.B.** ____________

PARENT/GUARDIAN AUTHORIZATIONS:

- ◻ I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.
- ◻ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.
- ◻ Parent is responsible for auto-injectors for before and after school activities (there is no nurse available).

EMERGENCY CONTACTS:

	NAME	HOME #	WORK #	CELL #
PARENT/GUARDIAN				
PARENT/GUARDIAN				
OTHER:				
OTHER:				

I understand that submission of this form may require the Nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication. My signature below provides authorization for this contact. I also understand that a signature is mandatory for school acceptance of this form.

Parent/Guardian Signature: ____________________ Phone:____________ Date:__________

STUDENT AGREEMENT:

- ◻ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- ◻ I agree to carry my auto-injector with me at all times;
- ◻ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when my auto-injector (epinephrine) is used;
- ◻ I will not share my medication with other students or leave my auto-injector unattended;
- ◻ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: ______________________________ **Date** ____________

Approved by Nurse, Signature: ______________________ **Date** ____________

***PREVENTION*:** Avoidance of allergen is crucial to prevent anaphylaxis.

Critical components to prevent life threatening reactions: **√ Indicates activity completed by school staff**

	Encourage the use of Medic-Alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex Reduced Environment" sign at entrance(s) of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

STAFF MEMBERS TRAINED:

NAME	TITLE	LOCATION/ROOM	TRAINED BY (RN only)

Rev 7/09

Form adapted from the Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, Alaska Chapter

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Physician)

Student Name: ______________________ **Date Of Birth:** ____/____/____ (MONTH) (DAY) (YEAR)

☐ **Exercise Pre-Treatment:** Administer inhaler **(2 inhalations)** 15-30 minutes prior to exercise. (e.g., PE, recess, etc).

☐ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
☐ Levalbuterol (Xopenex HFA)
☐ Pirbuterol inhaler (Maxair)
☐ Use inhaler with spacer/valved holding chamber
☐ May carry & self-administer inhaler (MDI)
☐ Other: ______________________

Asthma Treatment

Give **quick relief medication** when student experiences asthma symptoms, such as coughing, wheezing or tight chest.

☐ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Pirbuterol (Maxair) 2 inhalations
☐ Use inhaler with spacer/valved holding chamber
☐ May carry & self-administer inhaler (MDI)
☐ Albuterol inhaled **by nebulizer** (Proventil, Ventolin, AccuNeb)
☐ .63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 ml
☐ Levalbuterol inhaled **by nebulizer** (Xopenex)
☐ 0.31 mg/3 mL ☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL
☐ Other: ______________________

Closely Observe the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are improved, student may return to classroom after notifying parent/guardian
- No improvement in symptoms, repeat the treatment and notify parent/guardian immediately
- ***If student continues to worsen, CALL 911 and initiate the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol***

Anaphylaxis Treatment

Give **epinephrine** when student experiences allergy symptoms, such as hives, difficulty breathing (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

☐ EpiPen® 0.3 mg
☐ EpiPen® Jr. 0.15 mg
☐ Other: ______________________
☐ May carry & self-administer epinephrine

CALL 911 **After Giving Epinephrine & Closely Observe the Student**

- Notify parent/guardian immediately
- *Even* **if student improves, the student should be observed for recurrent symptoms of anaphylaxis in an emergency medical facility**
- ***If student does not improve or continues to worsen, initiate the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol***

☒ This student has a medical history of asthma and/or anaphylaxis and I have reviewed the use of the above-listed medication(s). If medications are self-administered, the school staff **must** be notified.

Additional information: *(i.e. asthma triggers, allergens)* ______________________

Physician name: *(please print)* ______________________ **Phone:** ______________

Physician signature: ______________________ **Date:** ______________

Parent signature: ______________________ **Date:** ______________

Reviewed by school nurse/nurse designee: ______________________ **Date:** ______________

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