Plano Independent School District
Severe Allergy Emergency Action Plan

Name_____**DOB**_____**ID#**_____**Gr./Tea./Sec.**_____ **School Yr.**_____**Bus #** _____

ALLERGY TO:_____ Place Picture Here

Asthmatic? ☐ Yes* ☐ No *Higher risk for severe reaction

Prescribed Treatment

Physician is to check the actions to be taken for each of the symptoms listed below.

System	Symptom	Observe	Epinephrine	Antihistamine
	Ingestion with ***no 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 cough, wheezing	☐	☐	☐
Heart*	Weak, thready pulse, low blood pressure, fainting, pale, blueness	☐	☐	☐
Other		☐	☐	☐
	Progressing Reaction: Several systems involved	☐	☐	☐

Items with an * are potentially life threatening. The severity of the symptoms can change quickly. Monitor for side effects of epinephrine injection: nervousness, palpitations, fast heart rate, sweating, tremor, anxiety, dizziness, headache, nausea, vomiting, or weakness.

DOSAGE

Epinephrine: inject intramuscularly by auto-injector: ☐ 0.3mg ☐ 0.15 mg

Give second epinephrine dose after _____ minutes if no improvement and EMS has not arrived.

Antihistamine: give _____ (medication / dose / route)

Other: _____ (medication / dose / route)

Physician Consent for Self Administration of epinephrine auto-injector

I have instructed the student named here in the proper way to use his/her epinephrine auto-injector. It is my professional opinion that this student _____ s**hould / _____should not** (check one) be allowed to carry and self-administer his/her epinephrine auto-injector while on school property or at school-related events. **Physician Initials** _____

Physician's Name _____**Phone**_____

Physician's Signature _____ **Date** _____

Parent Consent / Anaphylaxis

Name_____ID#_____DOB_____Gr. / Tea. / Sec._____Date _____

Emergency Contacts

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency Contacts:

Name	Telephone #	Relationship
1.		
2.		
3.		

Even if parent/guardian cannot be reached, do not hesitate to medicate or take the student to a medical facility!

Background Information (Completed by parent or physician)

Please describe the circumstances under which you became aware that your child has a severe allergy to the substance listed on page 1 (e.g. Reaction after ingestion, sting or exposure to allergen, allergy skin testing, etc.) Describe your child's reaction.

Has the student ever experienced a life threatening reaction in the past that required emergency room care or hospitalization? What care was needed at that time?

Parent Consents

Parent Consent for Self Administration of Epinephrine Auto-injector

I, the parent of the student named here, ☐ **do** / ☐ **do not** (check one) agree with his/her physician to allow my child to carry his/her epinephrine auto-injector. If my child carries her/her own, I realize that the school clinic will not have his/her personal epinephrine autoinjector unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self- administer epinephrine. **Parent Initials** _____

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer epinephrine auto-injector

I ☐ **do /** ☐ **do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer epinephrine auto-injector to my child while in attendance at Plano ISD or Plano ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein.
Parent initials _____

Parent/Guardian Consent to Share Information and Picture.

I ☐ **do** / ☐ **do not** (check one) authorize Plano ISD to display a picture of my child and identify that this is a person with a severe allergy. I understand that school staff that comes into contact with my child will be given allergy information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent Initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of epinephrine auto-injector to the student and/or Student's self-administration of the epinephrine auto-injector. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of epinephrine auto-injector to the student, Student's self-administration of epinephrine auto-injector, or the disclosure of the student's Individually Identifiable Health Information, including *but not limited to* claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms and self-administer his/her administration of epinephrine auto-injector, negligently failed to recognize symptoms requiring the use of epinephrine auto-injector misconstrued symptoms which it believed necessitated the use of epinephrine auto-injector administered or failed to administer epinephrine auto-injector and/or "over-disclosed" my child's health information. Parent Initials _____

The School Health Administrative Guidelines developed by the Plano Independent School District are subject to the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101, et seq.- Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 701, et seq.- and the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 etseq.

Parent's Name _____ **Phone** _____

Parent's Signature _____ **Date** _____