SEVERE ALLERGIC REACTION MANAGEMENT PROCEDURE QUESTIONAIRE

Student Name: _____ Current Date: _____

Date of Birth: _____ Grade: _____

1. Describe in detail what your child is allergic to:

2. How often does your child have a severe reaction?

3. Describe the type and severity of the reaction:

4. When was your child's last attack?

5. When was your child's last hospitalization?

6. What do you do for an attack (e.g., medications, doctor visits):

7. Does your child have any side effects to medication he/she is now taking or takes for the attacks?

8. Does your child understand about this allergic reaction and how to avoid the allergens?

9. What would you like the school to do if your child has a reaction?

With the above information the school nurse will need to develop an allergic reaction plan:
☐ YES ☐ NO

_____ _____

Parent Signature Date

Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

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

Extremely reactive to the following foods: _____

THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

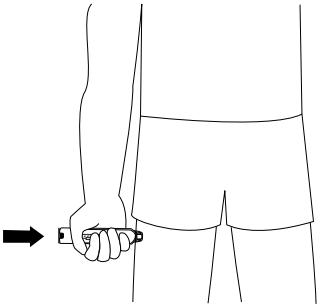
TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

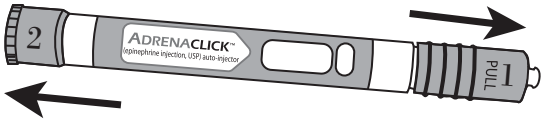
- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

KLEIN INDEPENDENT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

STUDENT:_____ DATE OF BIRTH:_____

In an effort to promote student health and maintain school performance, it is necessary that medication be given during school hours.

Physician's request for giving medication(s) during school hours:

NAME OF MEDICATION	DAILY DOSAGE	SCHOOL DOSAGE	TIME TO BE GIVEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Comments: (Reason for medication, possible side effects, etc.)

_____

_____

*No injections may be given except those needed in emergency situations or those necessary for the student to remain in school (i.e. insulin, epinephrine).

Physician's Signature: _____ Date: _____

Physician's Name (**Please Print**): _____Phone: _____

****

Klein school personnel are not permitted to give medication of any kind, including aspirin, similar preparations, or any other drugs, unless the parent requests in writing that there is a need for such medication. Non-prescription medications needed for longer than two weeks must also have a written request from a physician. When administering prescription medicines, the school district would prefer to have a written statement from a physician or dentist licensed to practice in the United States. Information, however, placed on a prescription label, if it is precise and clear to the school nurse, may be substituted for the above noted statement. The prescription must be filled by a pharmacist licensed to practice in the United States. All medications must be in their original container and kept in locked storage in the office of the nurse or principal's designee and administered by the nursing staff or a school employee. If the circumstances are questionable, the school employee reserves the right to deny the parent's request. No vitamins, health food or herbal preparations will be given by any school employee. Neither prescriptions nor over the counter medications from foreign countries will be administered.

****

PARENT/GUARDIAN AUTHORIZATION

I hereby authorize school personnel to administer non-prescription medication to my child during school hours or prescription medication as prescribed by the physician. I understand that any non-prescription medication that is to be dispensed to my child longer than two weeks will also need a doctor's authorization. Also, I am aware that no medication dosage will be changed without an order from the prescribing physician.

*I **(do / do not)** authorize school personnel, at my oral request, to administer dosages of medication in addition to the dosages specified on this form, if necessary for my child to receive the daily dosage prescribed by his or her doctor and specified on this form. If I make such a request, I shall ensure that I provide the school with additional medication thereafter to enable the school to continue making the scheduled school dosages*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: _____

Item No. 19.5550
Revised 1/26/95, atty.
Updated 8/28/01 atty.

Clear all fields

KLEIN INDEPENDENT SCHOOL DISTRICT
NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name: DOB: School:

We are requesting that you authorize Klein ISD (or its agent) to speak with the party specified regarding the above-named student and the release or request of specified records containing confidential information regarding the above-named student.

☐ KLEIN I.S.D. HAS PERMISSION TO RELEASE INFORMATION TO:

Name: Phone:

Address:

City: State: Zip:

☐ KLEIN I.S.D. HAS PERMISSION TO REQUEST INFORMATION FROM:

Name: Phone:

Address:

City: State: Zip:

RECORDS REQUESTED
- ☐ All Educational Records
- ☐ Transcript & Immunizations
- ☐ Academic Assessments
- ☐ Psychological Assessment
- ☐ Comprehensive Assessment
- ☐ Speech/Language Assessment
- ☐ Vocational Assessment
- ☐ OT/PT Assessments
- ☐ Medical Reports
- ☐ ARD/EP Reports
- ☐ Individual Translation Plans
- ☐ Other: _____

PURPOSE OF DISCLOSURE:
☐ Health Planning ☐ Educational Planning ☐ Student Transfer ☐ Other:

If you wish to have more information or if you have any questions, please contact the following staff person:

Name: Phone:

__Yes __No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.

__Yes __No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of the signature.

Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of the child or the provisions of a free appropriate public education.

_____ Date: _____
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_____ Date: _____
Signature of Interpreter, if used

Please return to: Name Date Mailed/Sent: Address
City/State/Zip

KLEIN ISD
FUTURE READY
www.kleinisd.net

Health Services

Date:

To The Parents/Guardians of:

You have indicated that your child has a food allergy that requires food substitution by the Klein ISD Nutrition and Food Services Department. The U.S.D.A. rules require that life threatening food allergies be documented by your child's physician on the Physician's Diet Modification Form, (attached). Upon completion of this form, diet modifications or substitutions will be provided in the school cafeteria and for snacks during state mandated testing.

If you have any questions or concerns please contact your school nurse. Your assistance in assuring food safety for your child is greatly appreciated.

Check one option below, sign and return to the campus nurse.

___ My child **does not** suffer from a life-threatening food allergy & **does not** require food substitutions at school.

Parent/Guardian Signature _____ Date: _____

____ My child **has** a life threatening food allergy to _____. My child's physician has completed the Klein ISD Physician's Diet Modification form.

Parent/Guardian Signature _____ Date: _____

____ My child **has** food allergies, but meals will be provided from our home. Food substitution in the cafeteria and during classroom activities is **not required**.

Parent/Guardian Signature _____ Date: _____

Ms. Laurie G. Combe, MN, RN • Health Services Coordinator • lcombe@kleinisd.net • 832-249-4315
Klein Instructional Center • http://www.kleinisd.net

KLEIN INDEPENDENT SCHOOL DISTRICT
PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Student Name_____ Date of Birth _____
Klein ISD ID #_____ Campus Name_____
Parent/Guardian Name_____
Parent Phone Number(s) Home_____ Cell _____

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a "person with a disability" is any person who has a physical or metal impairment that substantially limits one or more major life activities and has a record of such impairment or is regarded as having such impairment.

STUDENTS WITH DISABILITIES
PHYSICIAN'S STATEMENT

Date: _____

I _____, declare the child listed above to possess the following DISABILITY.
Physicians Name (Please PRINT)

1. **List any disability requiring meal modification:**_____
2. **Explanation of why this disability restricts diet:**_____
3. **The major life activity affected by the disability,** (caring for one's self, eating, performing manual tasks, walking, seeing, hearing, breathing, learning and working)_____
4. **Foods to be omitted:** _____ Fluid Milk _____ All dairy products _____ Wheat _____ Gluten
   _____ Whole Eggs _____ All foods containing egg as an ingredient _____ Soy _____ Seafood
   _____ Whole Corn _____ All foods containing corn additives (corn syrup, etc.)
   _____ Peanuts _____ All Nuts _____ All foods produced in a facility with nut containing products.
   Other (Please be Specific):_____
5. **Foods to Substitute (please check one box)**
   - ☐ **Foods not containing allergen**
   - ☐ **Specific food items:** _____

_____ _____ _____
Physician's Signature **Clinic/ Facility Name & Address** **Telephone**

For Office Use Only
Date Received from Physician: _____ Received by: _____
Date Forwarded to Nutrition & Food Services (Tiffany Muecke FSO): _____ Forwarded by: _____
Date Received at Nutrition& Food Services: _____ Received by: _____

Name: _____ **Medical Diagnosis:_____**

Birth Date: _____ **ID:_____**

_____has the potential for anaphylactic shock secondary to severe food allergy.

(Name)

Nursing Diagnosis	Goals	Interventions	Outcome

Risk for ineffective breathing related to bronchospasm and inflammation of airways secondary to allergic reaction.	Student will have IHP in place to include student, parental and staff roles in preventing and managing an anaphylactic reaction	Secure medical documentation of food allergy, treatment plan, food substitutions (Emergency Action Plan=EAP)
		• Educate school staff on early signs of potential anaphylaxis and appropriate steps in emergency care.
		  ○ School wide staff awareness training on recognition of signs of allergic reaction.
		  ○ Student specific training for classroom, administrative, cafeteria, custodial and transportation personnel.
		  ○ Train designated staff in use of Epinephrine auto-injector, first aid care, EMS contact.
		  ▪ 201_-201_ Staff Trained (add to list yearly)
		  • _____
		  • _____
		  • _____
		Designated personnel receive copy of EAP & IHP.
			*Medical documentation received-EAP.
			*Yearly staff awareness training documented.
			*Student specific training delivered and documented in student file.
			*Staff demonstrates proper use of epinephrine auto-injector.
			In event of allergic reaction, staff responds in accordance with EAP.
			*Staff responds to student report of allergen exposure and either supports student providing self-care or by administering epinephrine auto-injector.
			*Post crisis review conducted in event of food allergen exposure.

	Student will demonstrate awareness of the significance of allergic reactions, symptoms and treatment.	Review with student: • Food allergen and potential that allergen may be a “hidden” ingredient. • Procedures to follow if they perceive a situation that may expose them to food allergen. • Treatment methods including how/when to report allergic symptoms to school personnel.	*Student will read food labels before ingestion. *Student will not accept food offered by other students *Student demonstrates assertiveness when encountering situations that have potential to result in exposure to food allergen.

		Ensure that students who have permission to carry epinephrine auto-injector have adequate knowledge to perform self-care. Educate as necessary to ensure student and school community safety.	*Student will identify allergic reactions, notify school personnel and treat immediately.
	Establish a food safe environment for students with food allergies.	Educate staff regarding allergen and institute environmental controls. • All students/personnel wash hands or use hand wipes before and after food consumption/handling. Emphasize that hand sanitizer is NOT effective in removing allergens from hands or other surfaces. • Review food allergy and exposure prevention with food service staff. • Secure medical documentation for food substitution. • Secure "emergency meal" from parent in event food allergen cannot be avoided. • Review cleaning procedures with custodial staff. Establish a food safe environment for students with food allergies. • Notify classroom parents of need to restrict presence of food allergen in student's classroom activities. • Avoid use of food for instructional/reward purposes. • Adhere to policy of NO food on Klein ISD buses except for students with medical need. • Separate seating for food allergic child and students requiring food on bus. • Minimum 2 week advance planning for field trips and other off campus activities. • Facilitate student participation in full range of school activities.	*Student is NOT exposed to allergen and has NO episodes of allergic reaction.

Potential for diminished self-esteem secondary to food allergy diagnosis.	Protect/Enhance student's self-image.	Zero tolerance for bullying related to food allergy. Educate student on assertiveness techniques. Empower student to educate classmates.	*Student does not experience bullying or discrimination related to food allergy. *Student demonstrates positive self-esteem related to food allergy via verbal and non-verbal communication.

Physician Name (Printed or Stamp) _____

Physician Signature: _____ Date: _____

Parent Name Printed: _____

Parent Signature: _____ Date: _____

Registered Nurse Name (Printed): _____

Registered Nurse Signature: _____ Date: _____

KLEIN ISD
FUTURE READY
www.kleinisd.net

Consent to Release Food Allergy Information

Dear Parent/ Guardian,

The Campus Allergy Management Team works to minimize exposure to food allergens for all students. While Klein ISD Nutrition & Food Services is dedicated to preventing allergen exposure, Klein ISD cannot control food items brought from home by other students. By alerting the parents of other students on the importance of allergen avoidance at school, we can minimize the occurrence of food allergen exposure to your child.

Klein ISD has formulated a parent letter that can be distributed to your child's class advising them of a student with a food allergy. The letter does not identify your child, but details what food allergens should be left at home and steps to avoid cross contamination. A copy of this letter is attached.

By signing this consent, you are stating you have reviewed the aforementioned parent letter and agree to have the letter distributed to your child's homeroom class.

_____ _____

Student's Name **Student ID**

_____ _____

Signature of Parent, Guardian, Surrogate Parent, or Adult Student Date:

_____

Printed Name

_____ _____

Signature of Interpreter, if used Date:

_____

Printed Name of Interpreter, if used

Dear Parents,

A student in your child's class has a severe allergy to _____. A child with this type of allergy is at risk of developing anaphylaxis; a potentially life threatening event. Anaphylaxis can occur when a person eats; touches or inhales the food they are allergic to. Therefore, in order to promote the safety and well being of this student, we would like your cooperation with the following procedures.

- Please do not send any foods containing _____ to be eaten as snacks in the classroom. It is o.k. to send these products for lunch to be eaten in the cafeteria.
- Please do not enclose candy or other treats with seasonal cards.
- If **your child** ate _____ for breakfast, make sure that his/her hands are washed with soap and water before leaving for school. Water alone or hand sanitizers do not remove allergens.

Thank you for your cooperation with our food allergy management procedures.

_____
School Nurse Signature

_____
Telephone