Wylie ISD
.....building our future

Request for Severe Allergy Information

Dear Parent,

You have disclosed that your child has a severe allergy. Wylie ISD requires additional information in order to take necessary precautions for your Child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Allergy Action Plan – Must be updated and signed by the doctor and parent **every** school year. It includes Authorization for Self administration of Medication, and Authorization of Emergency Care.

2. Administration of Medication Request Forms (2) – One should be used for each medication sent to school. Includes permission to share information with Staff for the best possible care of your child.

Your child's supplies should include, if ordered in plan:

- EpiPen or EpiPen Jr with prescription label on it
- Antihistamine such as Benadryl

Please have your physician or other licensed health-care provider complete these forms and return them to the nurse as soon as possible. We appreciate your help in our effort to provide the best care for your child.

Sincerely,

Wylie ISD School Nurse
Phone:

<u>Please bring all supplies, wallet size photo of your child and this completed paperwork to the school nurse.</u>

REVISED: 10/17/2012 mm

WYLIE

PARENT REQUEST FOR ADMINISTRATION OF
MEDICATION BY SCHOOL PERSONNEL

- All prescribed and over the counter medication must be in a container labeled by the pharmacist or prescriber for the named student.
- Non prescription or over the counter medications must be age/wt appropriate, in the original container (NO BAGGIES) with the label intact and the student's name clearly written.
- The medication may be administered by a designate of the principal.
- A separate permission form is required for each medication.
- No expired medications will be accepted or administered.
- Sample medication will be accepted only with written directions from the physician.
- All medication not picked up by the parent on or before the last day of school will be discarded.

Student Name: _____ DOB/Age: _____ Grade:_____ Teacher:_____

Medication: _____ Strength(mg): _____ Exp date: _____

Physician: _____ Prescription #: _____

Condition for which medication is to be administered: _____

Specific Instructions: _____

Route of Medication: ORAL TOPICAL INHALANT INJECTABLE OTHER _____

When to Administer: Dosage may not exceed recommended dose without written instructions.

_____ DAILY _____ ONE TIME DOSE _____ AS NEEDED (PRN)

Time to be given: _____ Dosage: _____ tab cap tsp tbsp puffs vial ml (circle one)

Administer this medication until: _____ end of school year OR _____ specific date ___/___/_____

I authorize, as needed, the sharing of information regarding my child's health between the school nurse, Wylie ISD faculty/staff and the prescribing health care provider to ensure his/her health and safety during school hours.

I give my consent for the above medication to be administered to the above named student by Wylie ISD school personnel. I release Wylie ISD and their employees from any liability in dispensing the above medications.

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

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Severe Allergy Action Plan

Bus#_____ Morning
Bus#_____ Afternoon

Name:		**Severe ALLERGY to:**
		Other Allergies:
List specific symptoms experienced from past:		Asthma? ☐ Yes -High risk for severe reaction ☐ No
Date of Birth:	Grade:	Routine medications:

Location (s) where EpiPen / Rescue medications is/are stored:

☐ Nurse's Office ☐ Backpack/ Purse ☐ Coach/ Trainer ☐ Other_____

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/ or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/ abdominal cramps, vomiting, and/ or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out", fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS

MINOR REACTION such as hives, localized reaction, itching, nausea, abdominal cramps, hoarseness, or _____.

Antihistamine (ie Benedryl or Diphenhydramine): _____cc/mg Give _____ tsp or tablets

MAJOR REACTION such as wheezing, shortness of breath, thready pulse, unconsciousness, worsening symptoms after Antihistamine, or _____.

☐ **EpiPen** (0.3 mg) ☐ **EpiPen Jr.** (0.15)

It is medically necessary for this student to carry and EpiPen during school hours.	Yes ☐	No ☐
Student may self-administer Epi-Pen.	Yes ☐	No ☐
Student has demonstrated use to Licensed Provider.	Yes ☐	No ☐

Licensed Health Care Provider's Signature: **Date:**

Parent Signature: **Date:**

ACTION PLAN

- GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.
  - NOTE TIME _____ AM/ PM (EpiPen/adrenaline given)
  - NOTE TIME_____ AM/ PM (Antihistamine given)
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epipen is administered.**
- **DO NOT HESITATE to administer EpiPen and to call 911 if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and EpiPen is being administered.
- An adult trained in CPR is to stay with student-monitor and begin CPR if necessary.
- Call the Nurse's office _____ extension _____or office _____.
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - Notify administration and parent/ guardian
  - Dispose of used EpiPen in "sharps" container or give to EMS along with copy of the IHP.

Nurse will fill out staff members.

TRAINED STAFF MEMBERS

1. _____ Room _____

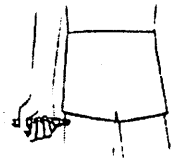
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

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



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**

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

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**

- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

June/2007