Cypress-Fairbanks Independent School District

Health Services: Allergy & Anaphylaxis Action Plan

Name: ______________________________ Student ID: ________________ DOB: _____/_____/______

Allergy to: ____ Asthma: [ ] **Yes** (↑ risk for a severe reaction) [ ] **No**

Student to sit at "allergen aware" table (utilized only by other students with severe food allergies) during school lunch: [ ] **Yes** [ ] **No**

MEDICATION(S)

Epinephrine brand: ____________________________

Epinephrine dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten, and call 911.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted and call 911.

Antihistamine brand or generic: ____________________

Oral antihistamine dose: __________________________

Other (e.g. INH if wheezing): _______________________

SELF-ADMINISTRATION

To be completed by prescribing healthcare provider (HCP) only.

I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

[ ] allowing student self-transport/administration of epinephrine for the current school year. During my assessment the student verbalized the purpose of the medication, the time/circumstance to administer, and when to seek help from school staff.

[ ] restricting permission to self-transport/administer epinephrine and reevaluating permission at a later date.

[ ] other: ____________________________

SYMPTOMS (mild to severe)		**TREATMENT** (as checked)	
CFISD staff will **administer medication(s)** as prescribed, **contact 911** for epinephrine administration, and **notify parents/guardians** of action plan initiation (mild or severe response).			
Nose:	itchy/runny, sneezing	[ ] epinephrine & 911	[ ] antihistamine
Mouth:	itchy, tingling	[ ] epinephrine & 911	[ ] antihistamine
Mouth:	significant swelling of the tongue and/or lips	[ ] epinephrine & 911	[ ] antihistamine
Gut:	nausea/mild discomfort	[ ] epinephrine & 911	[ ] antihistamine
Gut:	repetitive vomiting, severe diarrhea, severe discomfort	[ ] epinephrine & 911	[ ] antihistamine
Throat:	tight, hoarse, trouble breathing/swallowing or swelling	[ ] epinephrine & 911	[ ] antihistamine
Heart:	pale, blue, faint, weak pulse, dizzy	[ ] epinephrine & 911	[ ] antihistamine
Lung:	short of breath, wheezing, repetitive cough	[ ] epinephrine & 911	[ ] antihistamine
Skin:	few hives, mild itch	[ ] epinephrine & 911	[ ] antihistamine
Skin:	many hives over body, widespread redness	[ ] epinephrine & 911	[ ] antihistamine
Other:		[ ] & 911	[ ] antihistamine
[ ] **Repeat epinephrine** for symptoms lasting longer than _____ minutes after 1st dose			

____________________ ____________________ (_____) _____-_______ _____/_____/20_____

Printed name of HCP Signature of HCP Phone number Date

I agree with the recommendations of my child's HCP and authorize CFISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate CFISD employees for the current school year.

____________________ ____________________ (_____) _____-_______ _____/_____/20_____

Printed name, parent/guardian Signature parent/guardian Phone number Date

Revised 2/2017

Permission to Self-Transport/Administer Medication

Student Name: ______________________________ ID#: ____________ Grade: _____

With parent permission, a statement of the student's ability to self-transport/administer his/her medication from the prescribing medical provider, and a school nurse's evaluation, students in CFISD may self-transport/administer certain emergency medications. The medication must be transported in the **original container**, and the student should only carry a **daily dose of the medication.** The student is responsible to maintain his/her medication in an appropriate and accessible place at all times. The transport/use of undisclosed medications may result in disciplinary action according to the student code of conduct.

I, ______________________________ [parent/guardian name], give permission to my son/daughter to transport and self-administer the medication(s) listed below while on a school campus. My child has demonstrated his/her understanding of proper medication use and understands that the medications listed below are not to be shared with others or taken in any way other than directed by the prescribing physician or manufacturer. I also understand that the misuse of medications can result in disciplinary action for my child according to the student code of conduct. On this form, I have disclosed all medications that my child is permitted to carry.

Parent Signature: ______________________________ Date: ____/____/20____

I, ______________________________ [student name], understand proper medication use and that the medication(s) listed below is only for my use during the school day. I will be responsible with my medication(s), take it only as directed by the prescribing physician or manufacturer, store them in a safe place in my belongings, and I will not share them with others under any circumstance. I also understand that the misuse or sharing of my medications can result in disciplinary action according to the student code of conduct. I will seek assistance from the school nurse or a responsible adult if I must administer an emergency medication(s) while at any CFISD school.

Student Signature: ______________________________ Date: ____/____/20____

Medication 1: ____________________ Dose: ________________ Route: ________________
Reason for use: ______________________________ Expiration date: ____/____/20____

Medication 2: ____________________ Dose: ________________ Route: ________________
Reason for use: ______________________________ Expiration date: ____/____/20____

Medication 3: ____________________ Dose: ________________ Route: ________________
Reason for use: ______________________________ Expiration date: ____/____/20____

For school nurse use only

I certify that the student named above:

Knows the name and purpose of the medication(s) he/she will self-transport	Yes / No
Knows the prescribed medication dose	Yes / No
Articulates the appropriate time and circumstance under which the medication(s) should be administered	Yes / No
Demonstrates the correct administration of the medication(s) listed above	Yes / No
Understands the period for which the medication(s) is/are prescribed	Yes / No

School Nurse Signature: ______________________________ Date: ____/____/20____

Parent/Guardian Consent for Administering Medication

revised 6/16

Student name: ________________________ Grade: _____ Homeroom: __________ Student ID: __________ Allergies: __________

In compliance with CFSID Board policy FFAC (local), all medications administered by CFISD staff must be:

- delivered to the clinic by a parent/guardian or his/her designee (responsible adult),
- supplied in the original container (prescription bottle with prescription label or manufacturer's packaging and will only be administered in accordance with prescriber or manufacturer's guidelines),
- prescribed by a medical professional licensed with prescriptive authority in the state of Texas (unless US FDA approved medication available for purchase without a prescription),
- US FDA approved for safety and efficacy (school nurse must verify using reputable, peer-reviewed, evidence-based medical literature and may decline administration if she/he finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient),
- and retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year or the medication will be destroyed in accordance with District expectations.

I request Cypress Fairbanks ISD personnel to administer the medication(s) listed below for the 20_____- 20_____ school year:

Parent/guardian phone: (_______)________-__________ Parent/guardian email: ____________________

Med#1____________________	Med#2____________________	Med#3____________________
Exp. Date: __________Route:________	Exp. Date: __________Route:________	Exp. Date: __________Route:________
#1 Dose: __________Time: ________	#2 Dose: __________Time: ________	#3 Dose__________ Time: ________
Reason: ____________________	Reason: ____________________	Reason: ____________________
Date of request: _____/_____/20_____	Date of request: _____/_____/20_____	Date of request: _____/_____/20_____

I, ______________________, parent or guardian of student listed above, authorize the administration of the medication listed above for the current school year and authorize the school nurse or her designee to contact the prescribing healthcare provider for any clarification regarding the requested medication administration.

Sign/Date: ____________________	Sign/Date: ____________________	Sign/Date: ____________________
End of year disposition of medication: O Retrieved by parent/guardian O Destroyed by CFISD staff	End of year disposition of medication: O Retrieved by parent/guardian O Destroyed by CFISD staff	End of year disposition of medication: O Retrieved by parent/guardian O Destroyed by CFISD staff
Sign/Date: ____________________	Sign/Date: ____________________	Sign/Date: ____________________