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** 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. inhaler 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:		[ ] epinephrine & 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