



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	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Mouth:	itchy, tingling	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Mouth:	significant swelling of the tongue and/or lips	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Gut:	nausea/mild discomfort	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Gut:	repetitive vomiting, severe diarrhea, severe discomfort	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Throat:	tight, hoarse, trouble breathing/swallowing or swelling	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Heart:	pale, blue, faint, weak pulse, dizzy	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Lung:	short of breath, wheezing, repetitive cough	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Skin:	few hives, mild itch	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Skin:	many hives over body, widespread redness	<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
Other:		<input type="checkbox"/> epinephrine & 911	<input type="checkbox"/> antihistamine
<input type="checkbox"/> Repeat epinephrine for symptoms lasting longer than _____ minutes after 1 st 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____