Belton ISD Health Services
Parental Authorization for Life-Threatening Allergy Emergency Plan
School Year: 2019-2020 Campus:

Student Last Name	**Student First Name**	DOB	Grade/Homeroom	Transportation: ☐Rides bus #_____ ☐Car rider ☐ Walker

Life-threatening allergy to:

☐No ☐Yes Student in Special Education Program? ☐No ☐Yes Student in 504 Program? (School accommodations for those with chronic health conditions)
☐No ☐Yes Student has had a reaction that requires the use of Epinephrine
☐No ☐Yes Student permitted to carry & self-administer their Epinephrine
☐No ☐Yes Student has asthma (higher risk for allergic reaction)
☐No ☐Yes Student permitted to carry & self-administer their rescue inhaler
☐No ☐Yes Student understands how to avoid allergen/food
☐No ☐Yes Student knows when & how to tell an adult they may be having an allergy related problem

Questions related to life-threatening food allergy:
☐No ☐Yes Give Epinephrine immediately for **ANY symptoms** if the allergy was likely eaten
☐No ☐Yes Give Epinephrine immediately if the allergen was **definitely eaten, even if no symptoms noted**
☐No ☐Yes Student requires a special diet modification

Emergency med needed at school: Dosage/Route/Time	RX #	Expiration Date
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Medication will be kept at school: ☐N/A ☐In health office ☐Student will carry in backpack ☐Other: _____

Standard Life-Threatening Allergy Emergency Plan for School
Please review standard life-threatening allergy emergency plan for school and add additional instructions as needed

If you see one or more of the following potentially life-threatening symptoms:	**Do This:**
• 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: hives, itchy rashes, swelling (eyes. Lips, etc.) • Gut: vomiting, diarrhea, crampy pain **Or if you see a combination of symptoms from different body areas:** • Skin hives, itchy rashes, swelling (eyes, lips, etc.) • Gut: vomiting, diarrhea, crampy pain	☐**Immediately Inject Epinephrine _____(dose). Note time epinephrine was given** 1. Call 911. (Mr. MERT: call nurse/principal/parent) Inform operator epinephrine was given. Treat student even if parents cannot be reached. 2. Stay with student and monitor. For a severe reaction, consider keeping student lying on back with legs raised ☐A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. 3. If ordered, give additional medication: ☐Antihistamine**_____(name/dose) ☐If asthmatic, give inhaler: _____

Actions to Take for a Mild Allergic Reaction

If you see any of this:	**Do this:**
• Mouth: itchy mouth • Skin: few hives around face/mouth, mild itch • Gut: mild nausea/discomfort **The severity of the symptoms can quickly change.**	☐**Give antihistamine** _____(name/dose)** 1. Stay with student 2. Notify school nurse/principal/ parent that a suspected allergic reaction has occurred 3. If symptoms become more severe, use epinephrine as instructed above **IMPORTANT: Asthma inhalers and antihistamines cannot be depended on to replace epinephrine in anaphylaxis

Other instructions/ Plans to avoid allergen:

Physician: Print Name	Physician Signature	Physician Phone	Date

I grant permission to Belton ISD to administer this medication to my child. I am giving permission to BISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may give the medication.

Parental Signature	**Best emergency phone**	**Other phone**	**Date**
Emergency Contact	**Phone**	**Other phone**	

Trained Staff-Print name and initial after completing training on administering this medication, which includes seeking additional training or assistance as needed when administering this medication. **Trainer-** sign and date beside name of staff member that has completed the knowledge and skills to administer this medication.

Trained staff: Print Name/initial	Trainer Signature	Training Date	Trained staff: Print Name/initial	Trainer Signature	Training Date

If administered:	Date	Time	Initials	Date	Time	Initials

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Print page 2 if student will carry emergency medications for life-threatening allergy:

THE FOLLOWING IS TO BE COMPLETED BY THE SCHOOL NURSE for students who have received written authorization by the physician and parent <u>to carry and self-administer</u> their Epinephrine:

Yes **No**

☐ ☐ Demonstrated correct use/administration of Epinephrine.
☐ ☐ Recognizes early signs & symptoms of an allergic reaction and agrees to report immediately to nurse's office if present
☐ ☐ Agrees not to share medication with others
☐ ☐ Agrees to keep medication in: _____ (location)

The student <u>has demonstrated</u> the purpose, appropriate method and frequency of his/her Epinephrine. I feel he/she shows sufficient responsibility to carry the Epinephrine on his/her person in school.

THE FOLLOWING IS TO BE COMPLETED BY THE SCHOOL NURSE for students who have received written authorization by the physician and parent <u>to carry and self-administer</u> their rescue inhaler:

Yes **No**

☐ ☐ Demonstrated correct use/administration of asthma inhaler.
☐ ☐ Recognizes proper and prescribed timing for medication
☐ ☐ Agrees not to share medication with others
☐ ☐ Agrees to keep medication in: _____ (location)
☐ ☐ Agrees to come directly to the Nurse's Office if asthma symptoms persist

☐ **The student <u>has demonstrated</u> the purpose, appropriate method and frequency of his/her meter dose inhaler. I feel he/she shows sufficient responsibility to carry the inhaler on his/her person in school.**

Nurse Signature	Date