EAGLE MOUNTAIN SAGINAW ISD
Fostering a Culture of Excellence

Eagle Mountain-Saginaw ISD
Health Services
Allergy Health Plan

Form Date: _____

Student Name:	**Grade Level**:	
DOB:	**Age**:	
Emergency Contact 1:	**Relationship**:	**Phone**:
Emergency Contact 2:	**Relationship**:	**Phone**:
Primary Care Physician:	**Physician Phone**:	

Assessment Data

Known Allergies:	
Past Reactions:	
Date of Past Reaction:	**Treatment**:
Date of Past Reaction:	**Treatment**:
Other Health Conditions:	

Known Symptoms (Check All That Apply): * = **High Risk for Severe Reaction**

System:	**Symptoms**:
Mouth*	Itching and swelling of the lips, tongue, or mouth.
Throat*	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
Skin	Hives, itchy rash, and/or swelling about the face or extremities.
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea.
Lung*	Shortness of breath, repetitive coughing, and/or wheezing.
Heart*	Thready pulse "passing out."

Current Medications: (Home/School/Both, including OTC and alternative Meds)

Medication Name:		☐ **Home** ☐ **School**
Route:	**Dose**:	**Frequency**:
Storage Information:		
☐ **Student Carries**:		
☐ **Place Stored**:		
☐ **Back-up Medication Location**:		

Medication Name:		☐ **Home** ☐ **School**
Route:	**Dose**:	**Frequency**:
Storage Information:		
☐ **Student Carries**:		
☐ **Place Stored**:		
☐ **Back-up Medication Location**:		

☐ It is my opinion that the student should NOT carry his/her medication by him/herself.

☐ I have instructed the student in the proper way to use his/her medications. It is my professional opinion that he/she SHOULD be allowed to carry and use that medication by him/herself. **MD SIGNATURE REQUIRED**

1. Student knows action of the medication and reason for taking medication.
2. Student is aware of the possible side-effects of medication.
3. Student agrees to never share medication with anyone.
4. Student will always carry medication in correct container.
5. Student agrees to go to the nurse's office if symptoms are not relieved by medication.

If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

Physician Signature:	**Signature Date**:
Parent Signature:	**Signature Date**:
RN Signature:	**Signature Date**:

EAGLE MOUNTAIN SAGINAW ISD
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Eagle Mountain-Saginaw ISD
Health Services
Anaphylaxis Emergency Plan

Student Name:	**DOB**:
School:	**Grade Level:**
Parent/Guardian Name:	**Phone**:
Primary Care Provider:	**Phone**:
ALLERGIC to:	
History of Asthma: ☐ *Yes ☐ No	**History of Anaphylaxis**: ☐ *Yes ☐ No
*** = Indicates Risk for Sever Reaction**	

STEP 1: PREPARING For an Emergency

STEP 2: EVALUATING Their Reaction

STEP 3: TREATING Him/Her in an Emergency.

STEP 4: RE-EVALUATING

STEP 5: ALERTING Parent or Emergency Contacts

EPINEPHRINE DOSE: *Keep 2 doses on hand*
- ☐ EpiPen Jr (0.15 mg) up to 66 lbs
- ☐ EpiPen (0.3 mg) above 66 lbs
- ☐ Auvi-Q (0.3 mg) above 66 lbs

ANTIHISTAMINE TYPE + DOSE
- ☐ Benadryl (also Diphenhydramine)
  - ☐ 12.5 mg (1 tsp or 1 chewable)
  - ☐ 25 mg (2 tsp or 2 chewable)
  - ☐ 50 mg (4 tsp or 4 chewable)
- ☐ Other Antihistamine:

May self-carry medications: ☐ Yes ☐ No

May self-administer medications: ☐ Yes ☐ No

BODY SYSTEM	SYMPTOMS
☐ Mouth	Itching, tingling, or swelling of lips, tongue, or mouth.
☐ Skin	Hives, itchy rash, or swelling.
☐ Gut	Nausea, abdominal cramps, vomiting, or diarrhea.
☐ Throat	Tightening of throat, hoarseness, or hacking cough.
☐ Lung	Shortness of breath, coughing, or wheezing.
☐ Heart	Weak pulse, dizziness, fainting, or pale or blue skin.
☐ Other:	Other (List):

- If allergict food EATEN and…ANY SYMPTOMS other than mouth. - If allergic food NOT known to be eaten, plus TWO or more body systems of symptoms. - If bee sting.	- If allergic food EATEN and NO SYMPTOMS - If allergic food EATEN and…SYMPTOMS only in and around mouth.
1. GIVE EPINEPHRINE 2. CALL 9-1-1 3. GIVE ANTIHISTAMINE 4. RE-EVALUATE AS IN STEP 4	☐ 1. GIVE ANTIHISTAMINE 2. CONTINUE TO WATCH FOR SYMPTOMS ***OR*** ☐ 1. GIVE EPINEPHRINE 2. CALL 9-1-1 3. GIVE ANTIHISTAMINE 4. RE-EVALUATE AS IN STEP 4

Re-Evaluating:

☐ See additional page.

Watch child closely until transport to Emergency Department. If symptoms of throat, lung, or heard are worsening or not improving, GIVE a second dose of Epinephrine after 5 MINUTES.

Parent or EC 1:	Phone:
Parent or EC 2:	Phone:

Physician Signature:	**Signature Date**:
Parent Signature:	**Signature Date**:

Parent Statement of Food Allergy Information

Pursuant to HB 742, school districts are required to request that a parent of an enrolling student disclose whether the student has a food allergy or a severe food allergy.

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the District in order to enable the District to take necessary precautions for your child's safety.

A severe food allergy is a dangerous or life-threatening reaction of the human body to a food-borne allergen induced by inhalation, ingestion or skin contact that requires immediate medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's reaction to the food.

Food	Allergic Reaction
Food 1:	Reaction 1:
Food 2:	Reaction 2:

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Education Rights and Privacy Act and District Policy.

Student Name:		**Date of Birth**:
Grade Level:	**Campus**:	**Date**:
Parent/Guardian Name:		
Primary Phone:	**Second Phone**:	**Third Phone**:
Parent/Guardian Signature:		**Signature Date**:

Consistent with guidelines from the Texas Department of Agriculture, in order for the District to consider food substitutions for a student's food allergies, a signed medical statement must be provided.

Does the child's food allergy constitute a disability? ☐ Yes ☐ No
If Yes, how does the disability restrict the student's diet?
What major life activity is affected by the disability?

Foods to Avoid	**Foods to be Substituted**
Food to Avoid 1:	Food Substitute 1:
Food to Avoid 1:	Food Substitute 2:
Food to Avoid 3:	Food Substitute 3:

Physician Signature:	**Signature Date**:

To be completed by school personnel:	
Date form sent home to parents:	Date form received by the School Nurse:
Date provided to Child Nutrition (if applicable):	Date provided to Transportation Dept. (if applicable):

Allergy Free Table

You have indicated that your child has severe food allergies. In order to prevent accidental exposure in the cafeteria, an allergen free table will be offered during all lunches. Only students with lunches that do not contain the allergen will be allowed to sit at this table.

Please check the box below indicating whether your child will be sitting at the allergy-free table.
I ☐ Do ☐ Do Not want my child to sit at the allergen free table during lunch.

Date:	
Student:	**Grade Level**:
Campus:	**Advisor/Teacher**:
Parent/Guardian Name:	
Parent/Guardian Signature:	**Signature Date**:

To be completed by school personnel:
Date form received by School Nurse:
Date cafeteria personnel notified of allergen free table:
Date custodial staff notified of allergen free table: