SEVERE ALLERGIC REACTION MANAGEMENT PROCEDURE QUESTIONAIRE

Student Name: _____ Current Date: _____

Date of Birth: _____ Grade: _____

1. Describe in detail what your child is allergic to:

2. How often does your child have a severe reaction?

3. Describe the type and severity of the reaction:

4. When was your child's last attack?

5. When was your child's last hospitalization?

6. What do you do for an attack (e.g., medications, doctor visits):

7. Does your child have any side effects to medication he/she is now taking or takes for the attacks?

8. Does your child understand about this allergic reaction and how to avoid the allergens?

9. What would you like the school to do if your child has a reaction?

With the above information the school nurse will need to develop an allergic reaction plan:
☐ YES ☐ NO

_____ _____

Parent Signature Date

Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

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:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

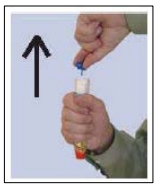
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

PROCEDURE FOR EPIPEN OR EPIPEN JR AUTO-INJECTOR

Step 1. Prepare EpiPen or EpiPen Jr for Injection

Flip open the yellow cap of your EpiPen or the green cap of your EpiPen Jr carrier tube.

Tip and slide the auto-injector out of the carrier tube.



Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
With your other hand, **remove the blue safety release by pulling straight up** without bending or twisting it.

Note: The needle comes out of the orange tip. To avoid an accidental injection, never put your thumb, fingers or hand over the orange tip. If an accidental injection happens, get medical help right away.

Step 2. Administer EpiPen or EpiPen Jr for Injection

If you are administering to a young child, hold the leg firmly in place while administering an injection.

Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
Swing and push the auto-injector firmly until it 'clicks'. The click signals that the injection has started.

Remove the auto-injector from the thigh. The orange tip will extend to cover the needle. If the needle is still visible, do not attempt to reuse it.

Hold firmly in place for 3 seconds (count slowly 1,2,3).
The injection is now complete.

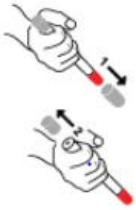
Massage the injection area for 10 seconds.

Step 3. Get Emergency Medical Help Now

You may need further medical attention, **CALL 911**. **You may need to use a second EpiPen or EpiPen Jr Auto-Injector if symptoms continue or recur.**

PROCEDURE FOR EPINEPHRINE USP AUTO-INJECTOR

Step A



- Pull off GRAY end cap with the [1]; you will now see a **RED** tip. Never put thumb, finger, or hand over the **RED** tip.
- Pull off GRAY end cap with [2].

Step B

- Put the **RED** tip against the middle of the outer side of your thigh (upper leg) as shown. It can go through clothes.
- Press down hard until the needle enters your thigh (upper leg) through your skin. Hold it in place while slowly counting to 10.
- Remove the epinephrine auto-injector from your thigh.
- Check the **RED** tip. If the needle is exposed, you received the dose. If the needle is not visible, repeat Step B.

Step C

Get emergency medical help right away: Call 911.

An allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts:

Name/Relationship: _____Phone: (___) _____-_____

Name/Relationship: _____Phone: (___) _____-_____

TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

KLEIN INDEPENDENT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

STUDENT:_____ DATE OF BIRTH:_____

In an effort to promote student health and maintain school performance, it is necessary that medication be given during school hours.

Physician's request for giving medication(s) during school hours:

NAME OF MEDICATION	DAILY DOSAGE	SCHOOL DOSAGE	TIME TO BE GIVEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Comments: (Reason for medication, possible side effects, etc.)

_____

_____

*No injections may be given except those needed in emergency situations or those necessary for the student to remain in school (i.e. insulin, epinephrine).

Physician's Signature: _____ Date: _____

Physician's Name (**Please Print**): _____Phone: _____

****

Klein school personnel are not permitted to give medication of any kind, including aspirin, similar preparations, or any other drugs, unless the parent requests in writing that there is a need for such medication. Non-prescription medications needed for longer than two weeks must also have a written request from a physician. When administering prescription medicines, the school district would prefer to have a written statement from a physician or dentist licensed to practice in the United States. Information, however, placed on a prescription label, if it is precise and clear to the school nurse, may be substituted for the above noted statement. The prescription must be filled by a pharmacist licensed to practice in the United States. All medications must be in their original container and kept in locked storage in the office of the nurse or principal's designee and administered by the nursing staff or a school employee. If the circumstances are questionable, the school employee reserves the right to deny the parent's request. No vitamins, health food or herbal preparations will be given by any school employee. Neither prescriptions nor over the counter medications from foreign countries will be administered.

****

PARENT/GUARDIAN AUTHORIZATION

I hereby authorize school personnel to administer non-prescription medication to my child during school hours or prescription medication as prescribed by the physician. I understand that any non-prescription medication that is to be dispensed to my child longer than two weeks will also need a doctor's authorization. Also, I am aware that no medication dosage will be changed without an order from the prescribing physician.

*I **(do / do not)** authorize school personnel, at my oral request, to administer dosages of medication in addition to the dosages specified on this form, if necessary for my child to receive the daily dosage prescribed by his or her doctor and specified on this form. If I make such a request, I shall ensure that I provide the school with additional medication thereafter to enable the school to continue making the scheduled school dosages*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: _____

Item No. 19.5550
Revised 1/26/95, atty.
Updated 8/28/01 atty.

Clear all fields

KLEIN INDEPENDENT SCHOOL DISTRICT
NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name: DOB: School:

We are requesting that you authorize Klein ISD (or its agent) to speak with the party specified regarding the above-named student and the release or request of specified records containing confidential information regarding the above-named student.

☐ KLEIN I.S.D. HAS PERMISSION TO RELEASE INFORMATION TO:

Name: Phone:

Address:

City: State: Zip:

☐ KLEIN I.S.D. HAS PERMISSION TO REQUEST INFORMATION FROM:

Name: Phone:

Address:

City: State: Zip:

RECORDS REQUESTED
- ☐ All Educational Records
- ☐ Transcript & Immunizations
- ☐ Academic Assessments
- ☐ Psychological Assessment
- ☐ Comprehensive Assessment
- ☐ Speech/Language Assessment
- ☐ Vocational Assessment
- ☐ OT/PT Assessments
- ☐ Medical Reports
- ☐ ARD/EP Reports
- ☐ Individual Translation Plans
- ☐ Other: _____

PURPOSE OF DISCLOSURE:
☐ Health Planning ☐ Educational Planning ☐ Student Transfer ☐ Other:

If you wish to have more information or if you have any questions, please contact the following staff person:

Name: Phone:

__Yes __No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.

__Yes __No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of the signature.

Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of the child or the provisions of a free appropriate public education.

_____ Date: _____
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_____ Date: _____
Signature of Interpreter, if used

Please return to: Name Date Mailed/Sent: Address
City/State/Zip

KLEIN ISD
PROMISE2PURPOSE

Request for Special Dietary Accommodations

Student Name_____ Date of Birth _____
Klein ISD ID #_____ Campus Name_____
Parent/Guardian Name_____
Parent Phone Number(s) _____ Email_____

1. **Will the student eat meals from the food service department? Breakfast ____ Lunch ____**
2. **Check one of the following that would require dietary accommodation:**

☐ **Life Threatening Allergy: *Complete Section A***

☐ **Physical/Mental Impairment (Immune, Digestion, Respiration, etc.): *Complete Section B***

Section A

Life Threatening Food Allergies: _____

1. **Foods to be omitted:** ____ Fluid Milk ____ All dairy products ____ Wheat ____ Gluten

____ Whole Eggs ____ All foods containing egg as an ingredient ____ Soy ____ Seafood

____ Whole Corn ____ All foods containing corn additives (corn syrup, etc.)

____ Peanuts ____ All Nuts ____ All foods produced in a facility with nut containing products.

Other (Please be Specific):_____

2. **Foods to Substitute (please check one box)**

☐ **Foods not containing allergen**

☐ **Specific food items: _____**

Section B

Physical/Mental Impairment: _____

Dietary Accommodation Required _____

_____

_____ _____ _____

Health Care Provider's Signature **Clinic/ Facility Name & Address** **Telephone**

_____ _____

Health Care Provider's Printed Name **Date form completed**

For Office Use Only

Date Received from Physician: _____ Received by: _____

Date Emailed to Nutrition & Food Services (cdybala1@kleinisd.net)_____ Forwarded by: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D. C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.