WEIMAR INDENDENT SCHOOL DISTRICT
SEVERE ALLERGY PLAN

Student's Name	DOB	Grade
Parent/Guardian	Phone	Cell
Emergency Contact	Phone	Cell
Allergy to:		Triggers:

Asthma: □ YES □ NO *Higher risk for sever reaction

Prescribed Treatment (Physician is to check the action to be taken for each of the symptoms listed below.)		
System:	**Symptom:**	**Given Checked Medication:**
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	□ Epinephrine □ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine □ Antihistamine
• Heart*	Weak or thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine
• Other*		□ Epinephrine □ Antihistamine
• If reaction is progressing (several of the above areas affected), give:		□ Epinephrine □ Antihistamine

Items with an * are potentially life threatening. The severity of the symptoms can change quickly. Monitor for side effects of epinephrine injection: nervousness, palpitations, fast heart rate, sweating, tremor, anxiety, dizziness, headache, nausea, vomiting, or weakness.

	Name of Medication	Dose	Route
Antihistamine			
Epinephrine			
Other			
Other			

Physician Consent for Self Administration of epinephrine auto-injector

I have instructed the student named here in the proper way to use his/her epinephrine auto-injector. It is my professional opinion that this student should/ should not (check one) be allowed to carry and self-administer his/her epinephrine auto-injector while on school property or at school-related events.

Physician Initials_____

Physician's Name_____ Phone_____

Physician's Signature_____ Date _____

10/2010, 4/2020

Parent Consents

Parent Consent for Self Administration of Epinephrine Auto-injector

I, the parent of the student named here, □ do/ □do not (check one) agree with his/her physician to allow my child to carry his/her epinephrine auto-injector. If my child carries her/her own, I realize that the school health office will not have his/her personal epinephrine auto injector unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self-administer epinephrine. **Parent Initials** _____

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Epinephrine Auto-injector

I, □ do/ □ do not (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer epinephrine auto-injector to my child while in attendance at Weimar ISD or Weimar ISD related events (such as field trips and athletic events); when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent Initials** _____

Parent/Guardian Consent to Share Information and Picture

I, □ do/ □ do not (check one) authorize Weimar ISD to display a picture of my child and identify that this is a person with a severe allergy. I understand that school staff that comes into contact with my child will be given allergy information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent Initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP , 504 plan, IEP, or other WISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of epinephrine auto-injector to the student and/ or Student's s elf- administration of the epinephrine auto-injector. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of epinephrine auto-injector to the student, Student's self-administration of epinephrine auto-injector, or the disclosure of the student's Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's know ledge and ability to identify symptoms and s elf -administer his/her administration of epinephrine auto-injector, negligently failed to recognize symptoms requiring the use of epinephrine auto-injector misconstrued symptoms which it believed necessitated the use of epinephrine auto- injector administered or failed to administer epinephrine auto-injector and/ or "over-disclosed" my child's health Information **Parent initials** _____

Parent/Guardian Name_____ Phone_____

Parent/Guardian Signature_____ Date _____

Emergency care in school:

Stay with student, call or have someone call for nurse immediately. Ask student if he/she uses an Epi-pen and if he/she has one with them. Send another person to get the Epi-pen if available. If nurse not present or available, call for someone trained in Epi-pen administration. Never send a student to the nurse alone if symptoms below are present.

- Difficulty breathing, repetitive coughing, wheezing
- Itchy rash, hives
- Difficulty swallowing, sense of itching tightness or
- Nausea, vomiting, diarrhea, abdominal cramps
  Tightness or in throat, hoarseness
- Flush/unusually pale skin
- Swelling (eyes, lips, tongue, extremities, etc.…)

Trained staff members

1. _____ room _____
2. _____ room _____
3. _____ room _____

EpiPen and EpiPen Jr. Directions

1. Remove EpiPen or EpiPen Jr. from the clear carrier tube.
2. Hold the auto-injector in your fist with the (orange) tip pointing downward.
3. With you other hand, remove the blue safety release by pulling straight up without bending or twisting it.
4. If you are administering EpiPen or EpiPen Jr. to a young child, hole the leg firmly in place while administering an injection.
5. Swing and push the auto-injector firmly to the outer thigh until it “clicks.” The click signals the injection has started.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove the auto-injector from the (outer) thigh. The (orange) tip will extend to cover the needle. If the needle is still visible, do not attempt to reuse it.
8. Massage the injection area for 10 seconds.
9. Call 911

For RN use only	Reviewed on
Nursing diagnosis:	Plan:
□ Stable history	No ongoing nursing management at school indicated
□ Potential for anaphylaxis	Standard procedure for severe allergic reaction
□ Other	Individualized health care plan
□ High risk for ineffective breathing pattern	
□ Delegated or assigned caregiver	RN signature: Date: