Lovejoy Independent School District
Severe Allergy Emergency Action Plan

School Year_____
BUS #_____

Name_____**DOB**_____**ID#**_____ **Tea./Sec.**_____

Place Child's Picture Here

ALLERGY TO: _____

Asthmatic? ☐ Yes* ☐ No *Higher risk for severe reaction

Step 1: Treatment

Symptoms:		**Give Checked Medication:** (To be determined by the physician authorizing treatment)	
If a food allergen has been ingested but ***no symptoms***: ☐ Observe		☐ Epinephrine	☐ Antihistamine
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 cough, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Weak, 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

***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.

DOSAGE

Epinephrine: inject intramuscularly ☐ EpiPen® ☐ EpiPen Jr.®

☐ Twinject™ 0.3mg ☐ Twinject™ 0.15 mg

☐ Give second epinephrine dose after _____ minutes if no improvement and EMS has not arrived.

Antihistamine: give _____
(medication / dose / route)

Other: _____
(medication / dose / route)

Step 2: Emergency Contacts

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency Contacts:

	Name	Phone #	Relationship
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____

Even if parent/guardian cannot be reached, do not hesitate to medicate or take the student to a medical facility!

Physician Designation of Rescue Drug

I have prescribed an EpiPen/Twinject for the student named here for use on an as needed basis. In recognition of the possible need to promptly administer this drug while in attendance at Lovejoy Independent School District, when a trained medical professional may not be available, I acknowledge that circumstances may arise in which an 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, may need to administer an EpiPen/Twinject to the named student.

☐ **I agree** / ☐ **I do not agree** (check one) **Physician Initials**______ **Parent Initials** __________

Physician Consent for Self Administration of EpiPen/Twinject

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

Physician's Name ____ **Phone**___________________

Physician's Signature____**Date**____________________

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Background Information (Completed by parent or physician)

Please describe the circumstances under which you became aware that your child has a severe allergy to the substance listed on the front. (e.g. Reaction after ingestion, sting or exposure to allergen, allergy skin testing, etc.) Describe your child's reaction.

____

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Has the student ever experienced a life threatening reaction in the past that required emergency room care or hospitalization? What care was needed at that time? ____

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Parent Consent for Self Administration of EpiPen/Twinject

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 EpiPen/Twinject. If my child carries her/her own, I realize that the school clinic will not have his/her personal EpiPen/Twinject 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 EpiPen/Twinject

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 EpiPen/Twinject to my child while in attendance at Lovejoy ISD or Lovejoy 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 Lovejoy 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 (nature of condition / 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 LISD 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 EpiPen/Twinject to the student and/or Student's self-administration of the EpiPen/Twinject. 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 EpiPen/Twinject to the student, Student's self-administration of EpiPen/Twinject,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 knowledge and ability to identify symptoms and self-administer his/her administration of EpiPen/Twinject, negligently failed to recognize symptoms requiring the use of EpiPen/Twinject(s), misconstrued symptoms which it believed necessitated the use of EpiPen/Twinject(s), administered or failed to administer EpiPen/Twinject(s), and/or "overdisclosed" my child's health information.

Parent's Name_____**Phone**_____

Parent's Signature_____**Date**_____