Wills Point Independent School District

Health Services

SEVERE ALLERGY ACTION PLAN

Name:_____ D.O.B._____ Grade/Teacher: _____

HISTORY OF ALLERGY REACTION

Allergic To: _____ Age discovered _____

Allergy Reaction was caused when substance was: ___ Ingested (eaten) ___ Contacted (touched) ___ Inhaled

Describe what happened (list symptoms): _____

_____

Was an emergency injection used for the allergy reaction? _____ If so, when? _____

Was student treated in an ER or hospitalized for an allergy reaction? _____ If so, when? _____

Do you take any special precautions to reduce student's risk of an allergy reaction? _____

_____

_____

Does student have a history of Asthma? No ___ *Yes ___ (*Higher risk for severe reaction)

To request a special diet or modification of a meal plan at school, please contact your campus nurse.

EMERGENCY CONTACTS

1. Doctor: _____ Phone: _____ Fax: _____
2. Name: _____ Phones: _____
   Relation: _____ Address: _____
3. Name: _____ Phones: _____
   Relation: _____ Address: _____

IF PARENT/GUARDIAN or PHYSICIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL EMS/911 FOR TRANSPORT TO MEDICAL FACILITY!

SIGNS OF AN ALLERGIC REACTION:

MOUTH Itching and swelling of the lips, tongue, or mouth
SKIN Hives, itchy rash, and/or swelling of the face or extremities
GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
THROAT* Itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
LUNG* Shortness of breath, repetitive coughing, and/or wheezing
HEART* Thready, weak pulse, passing out

The severity of symptoms can quickly change.

All above symptoms can potentially progress to a life-threatening situation.

Place Student's Photo Here

EMERGENCY ACTION PLAN AND MEDICATION AUTHORIZATION

(To be filled in by Physician)

FOR KNOWN OR SUSPECTED SEVERE ALLERGY REACTION/ANAPHYLAXIS:

- Give EPINEPHRINE intramuscularly *(Physician, circle one)*
  EpiPen 0.3mg **EpiPen Jr. 0.15mg** **Twinject 0.3mg** **Twinject 0.15mg**
- For mild allergy reactions (skin rash only) or in addition to Epinephrine injection give;
  Antihistamine: _____ Dose: _____ Route: _____
  Other: _____
- **CALL 911/RESCUE SQUAD**. Notify EMS that a severe allergic reaction has been treated and additional Epinephrine may be needed.
  Permission is granted for designated school personnel to administer above medication to student as prescribed by student's physician.
  Physician signature: _____ **Date:** _____
  Parent/Guardian signature: _____ **Date:** _____

*My signature indicates that I am giving permission for WPISD staff to contact the physician for additional information, if needed.

SELF-ADMINISTERED EMERGENCY MEDICATION

(To be filled in by Physician. *Medication Authorization on reverse side MUST be filled out.)

___I have instructed student,_____, in the proper way to use his/her emergency allergy medication. (See STUDENT CONTACT below.) It is my professional opinion that this student should be allowed to carry and self-administer his/her medication. *A second Epinephrine injection in the nurse's office is advisable.

___It is my professional opinion that this student should not carry or self-administer his/her emergency allergy medication.

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT CONTRACT FOR SELF-ADMINISTERED EMERGENCY ALLERGY MEDICATION

(This section must be completed by ALL students who will be carrying EMERGENCY medication.)

___I know how to administer my emergency medication and have discussed it with the nurse

___I know it is my responsibility to keep my medication with me so that it is easily accessible in case of an emergency during school hours, extracurricular activities, and field trips.

___I will tell a responsible adult/school nurse if I touch or eat a substance to which I am allergic or if I have symptoms of an allergic reaction.

___I will tell a responsible adult/school nurse if I have used my medication at school.

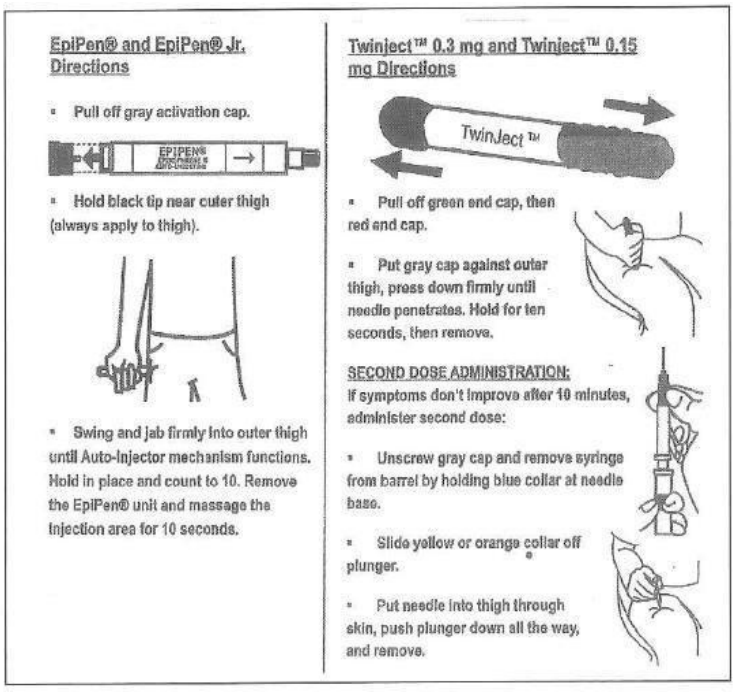
___I will inform the school nurse or my parents if my medication is lost, stolen, or has expired.

___I will not share my medication with anyone.

___I understand that a "back-up" Epinephrine injection in the nurse's office is advisable.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.
- Hold black tip near outer thigh (always apply to thigh).
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for ten seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and remove syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

Trained Staff Members:

Name: _____

Room: _____

Name: _____

Room: _____

Name: _____

Room: _____

Name: _____

Room: _____

Name: _____

Room: _____

Wills Point Independent School District does not discriminate against any student, employee or applicant for employment because of race, color, religion, gender, national origin, age, disability, pregnancy, military status, genetic information, political information, or on any other basis prohibited by law. Employment decisions will be made on the basis of each applicant's job qualifications, experience, and abilities.