ALLERGY &ANAPHYLAXIS

Anaphylaxis is a sudden, life threatening, severe allergic reaction. The most dangerous symptoms include breathing difficulties, a drop in blood pressure or shock. While Cuero ISD cannot guarantee an allergy-free environment at school, the district is committed to doing everything possible to ensure the safety of every child who has allergies. Campuses **do not** have an emergency supply of epinephrine or antihistamine available to them; therefore each student is responsible for having their own prescription medication. To ensure student safety, Parents/Guardians are required to bring the medication and necessary forms to the school and conference with the nurse.

Students who are at risk for developing anaphylaxis are entitled to carry and self-administer their anaphylaxis medications (epinephrine auto-injectors) while at school or a school event, if they met the legal requirements below:

- The medication and the self-administration must be authorized by a licensed health care provider and Cuero ISD Permission to carry Anaphylaxis Auto injector form.
- The student must demonstrate to the licensed health care provider and to the school nurse the skill level necessary to self-administer the medication.
- The student must have a current Allergy Action Plan on file with the School Nurse.

**** Please fill out the attached forms to ensure student safety******

1. Severe Allergic Reaction Management Procedure Questionnaire
2. Physician's Diet Modifications; to be completed by licensed health care Provider
3. Food Allergy and Anaphylaxis Emergency Care Plan; English or Spanish
4. Consent for Release of Confidential Information
5. Medication Permission form if applicable; to be completed by a licensed health care provider and parent permission signature on file in nursing office

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

PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Student Name_____ Date of Birth _____

ID #_____ Campus Name_____

Parent/Guardian Name_____

Parent Phone Number(s) Home_____ Cell _____

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a "person with a disability" is any person who has a physical or metal impairment that substantially limits one or more major life activities and has a record of such impairment or is regarded as having such impairment.

STUDENTS WITH DISABILITIES
PHYSICIAN'S STATEMENT

Date: _____

I _____, **declare the child listed above to possess the following DISABILITY.**
Physicians Name (Please PRINT)

1. **List any disability requiring meal modification:**_____
2. **Explanation of why this disability restricts diet:**_____
3. **The major life activity affected by the disability,** (caring for one's self, eating, performing manual tasks, walking, seeing, hearing, breathing, learning and working)_____
4. **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):_____
5. **Foods to Substitute (please check one box)**
   - ☐ **Foods not containing allergen**
   - ☐ **Specific food items:** _____

_____ _____ _____

Physician's Signature **Clinic/ Facility Name & Address** **Telephone**

For Office Use Only

Date Received from Physician: _____
Date Forwarded to Nutrition & Food Services _____
Date Received at Nutrition& Food Services: _____

Received by: _____
Forwarded by: _____
Received by: _____

Rev. 2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

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.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

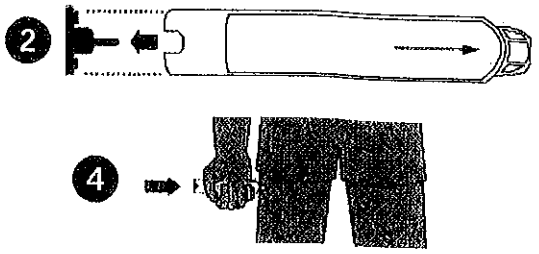
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

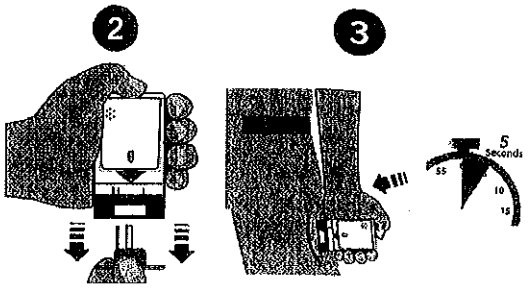
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



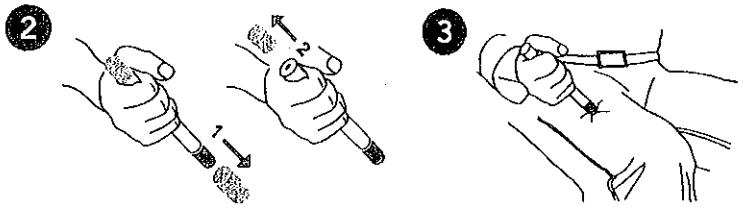
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE
Food Allergy Research & Education

PLAN DE ATENCIÓN DE EMERGENCIA EN CASO DE ALERGIA A ALIMENTOS Y ANAFILAXIA

Nombre: _____ Fecha de nacimiento: _____

Alergia a: _____

Peso: _____ libras Asma: [ ] **Sí (mayor riesgo de reacción grave)** [ ] No

COLOQUE LA IMAGEN AQUÍ

NOTA: No dependa de agentes antihistamínicos ni inhaladores (broncodilatadores) para tratar una reacción grave. USE EPINEFRINA.

Extremadamente reactivo a los siguientes alimentos: _____

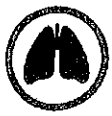
ENTONCES:

[ ] Si esta opción está marcada, administre epinefrina inmediatamente en caso de que se presente CUALQUIER síntoma si existe la posibilidad de que se haya ingerido el alérgeno.

[ ] Si esta opción está marcada, administre epinefrina inmediatamente si definitivamente se ingirió el alérgeno, incluso si no hay síntomas.

PARA **CUALQUIERA** DE LOS SIGUIENTES:

SÍNTOMAS **GRAVES**



PULMONES
Falta de aire, sibilancia, tos reiterada

CORAZÓN
Palidez, color azulado, desmayos, pulso débil, mareo

GARGANTA
Oclusión, voz ronca, dificultad para respirar/ tragar

BOCA
Hinchazón significativa de la lengua y/o los labios

PIEL
Muchas ronchas en el cuerpo, enrojecimiento generalizado

INTESTINO
Vómitos reiterados o diarrea grave

OTRA ÁREA
Sensación de que algo malo sucederá, ansiedad, confusión

O UNA COMBINACIÓN
de síntomas de diferentes áreas del cuerpo.

1. **INYECTE EPINEFRINA INMEDIATAMENTE.**
2. **Llame al 911.** Comuníqueles que el niño presenta un cuadro de anafilaxia y puede necesitar epinefrina a su llegada.

- Considere administrar más medicamentos luego de la epinefrina:
  - » Agentes antihistamínicos.
  - » Inhalador (broncodilatador) si hay sibilancia.
- Recueste al niño, levántele las piernas y manténgalo abrigado. Si tiene problemas para respirar o vomita, hágalo sentarse o recostarse sobre un lado.
- Si los síntomas no mejoran, o regresan, pueden administrarse más dosis de epinefrina aproximadamente 5 minutos o más después de la última dosis.
- Avise a los contactos de emergencia.
- Lleve al niño a la sala de emergencias incluso si los síntomas desaparecen. El niño debe permanecer en la sala de emergencias durante más de 4 horas porque los síntomas podrían volver a manifestarse.

SÍNTOMAS **LEVES**

NARIZ
Picazón/ secreción nasal, estornudos

BOCA
Picazón bucal

PIEL
Algunas ronchas, picazón leve

INTESTINO
Náuseas leves/ molestias

PARA **SÍNTOMAS LEVES** DE **MÁS DE UNA** DE LAS DIFERENTES ÁREAS DEL CUERPO, ADMINISTRE EPINEFRINA.

PARA **SÍNTOMAS LEVES** DE **UNA ÚNICA ÁREA** DEL CUERPO, SIGA LAS INDICACIONES A CONTINUACIÓN:

1. Se pueden administrar antihistamínicos, si así lo indica el médico.
2. Quédese con el niño; avise a los contactos de emergencia.
3. Observe detenidamente para detectar cambios. Si los síntomas empeoran, administre epinefrina.

MEDICAMENTOS/DOSIS

Marca de epinefrina: _____

Dosis de epinefrina: [ ] 0.15 mg por vía intramuscular
[ ] 0.3 mg por vía intramuscular

Agente antihistamínico de marca o agente antihistamínico genérico: _____

Dosis del agente antihistamínico: _____

Otro (p. ej., broncodilatador inhalable si hay sibilancia): _____

_____

FIRMA DE AUTORIZACIÓN DEL PADRE/MADRE/TUTOR LEGAL FECHA

FIRMA DE AUTORIZACIÓN DEL MÉDICO/PROVEEDOR DE ATENCIÓN MÉDICA FECHA

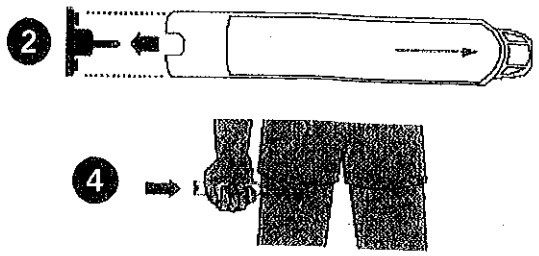
FORMULARIO PROPORCIONADO COMO CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

PLAN DE ATENCIÓN DE EMERGENCIA EN CASO DE ALERGIA A ALIMENTOS Y ANAFILAXIA

FARE
Food Allergy Research & Education

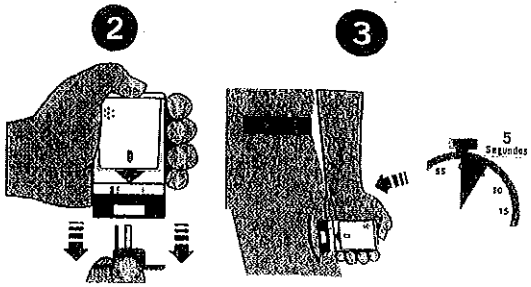
EPIPEN® (EPINEFRINA) INDICACIONES PARA EL AUTOINYECTOR

1. Retire el autoinyector EpiPen del estuche plástico.
2. Retire la tapa de seguridad azul.
3. Gire y presione firmemente la punta naranja en dirección a la parte exterior media del muslo.
4. Mantenga oprimido durante aproximadamente 10 segundos.
5. Retire el dispositivo y masajee el área durante 10 segundos.



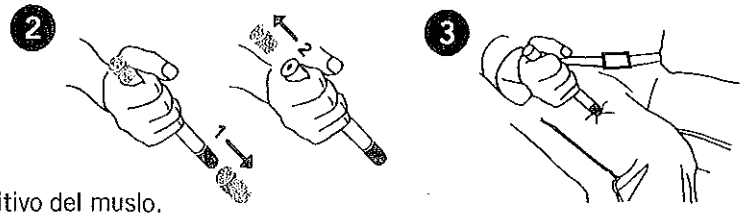
AUVI-Q™ (INYECCIÓN DE EPINEFRINA, USP) INDICACIONES

1. Retire el estuche de Auvi-Q. Esto activará automáticamente las instrucciones de voz.
2. Retire la tapa de seguridad roja.
3. Coloque el extremo negro contra la parte exterior media del muslo.
4. Presione con firmeza y mantenga oprimido durante 5 segundos.
5. Retire el dispositivo del muslo.



ADRENACLICK®/ADRENACLICK® GENÉRICO INDICACIONES

1. Retire el estuche.
2. Retire las tapas grises marcadas como "1" y "2".
3. Coloque la punta redondeada roja contra la parte exterior media del muslo.
4. Presione con firmeza hasta que penetre la aguja.
5. Mantenga oprimido durante 10 segundos. Retire el dispositivo del muslo.



OTRAS INDICACIONES/INFORMACIÓN (la epinefrina se puede llevar consigo; se puede autoadministrar, etc.):

Administre el tratamiento antes de llamar a los contactos de emergencia.
Los primeros signos de una reacción pueden ser leves, pero pueden empeorar rápidamente.

CONTACTOS DE EMERGENCIA: LLAME AL 911

EQUIPO DE RESCATE: _____

MÉDICO: _____ TELÉFONO: _____

PADRE (MADRE)/TUTOR(A): _____ TELÉFONO: _____

OTROS CONTACTOS DE EMERGENCIA

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

FIRMA DE AUTORIZACIÓN DEL PADRE/MADRE/TUTOR LEGAL FECHA

FORMULARIO PROPORCIONADO COMO CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

CUERO INDEPENDENT SCHOOL DISTRICT
Health Services

Physician Authorization for Medication Administration at School
(please complete for each medication)

_____ _____ _____
student **birthdate** **campus**

Medication to be administered: _____

Dosage: _____
Route: _____
Frequency/Time: _____

Purpose/Diagnosis: _____

Adverse Reactions: _____

Discontinuation Date: _____

Special Instructions: _____
_____

_____ _____
Physician **Date**

Parental Consent for Medication Administration

I, _____, **give consent for the school nurse to give my child the above listed medication, as prescribed.**

_____ _____
Parent/Guardian **Date**