Waller Independent School District

Health Services: Allergy & Anaphylaxis Action Plan with Nutrition Services Information

Name: ___________________________________ Student ID: ____________________ DOB: ______/______/_______

Allergy to: ____ Asthma: **[ ] Yes** (↑ risk for a severe reaction) **[ ] No**

Student to sit at "allergen aware" table (utilized only by other students with severe food allergies) during school lunch: **[ ] Yes [ ] No**

MEDICATION(S)

Epinephrine brand:

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

[ ] If checked, **give epinephrine immediately** if the allergen was definitely eaten, even if no symptoms are noted and call 911.

Antihistamine brand or generic:

Oral antihistamine dose:

Other (e.g. inhaler if wheezing):

____

SELF-ADMINISTRATION

To be completed by prescribing healthcare provider (HCP) only.

I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

[ ] allowing student self-transport/administration of epinephrine for the current school year. During my assessment the student verbalized the purpose of the medication, the time/circumstance to administer, and when to seek help from school staff.

[ ] restricting permission to self-transport/administer epinephrine and reevaluating permission at a later date.

[ ] other: ___________________________________

SYMPTOMS (mild to severe)		**TREATMENT** (as checked)	
WISD staff will **administer medication(s)** as prescribed, **contact 911** for epinephrine administration, and **notify parents/guardians** of action plan initiation (mild or severe response).			
Nose:	itchy/runny, sneezing	[ ] epinephrine & 911	[ ] antihistamine
Mouth:	itchy, tingling	[ ] epinephrine & 911	[ ] antihistamine
Mouth:	significant swelling of the tongue and/or lips	[ ] epinephrine & 911	[ ] antihistamine
Gut:	nausea/mild discomfort	[ ] epinephrine & 911	[ ] antihistamine
Gut:	repetitive vomiting, severe diarrhea, severe discomfort	[ ] epinephrine & 911	[ ] antihistamine
Throat:	tight, hoarse, trouble breathing/swallowing or swelling	[ ] epinephrine & 911	[ ] antihistamine
Heart:	pale, blue, faint, weak pulse, dizzy	[ ] epinephrine & 911	[ ] antihistamine
Lung:	short of breath, wheezing, repetitive cough	[ ] epinephrine & 911	[ ] antihistamine
Skin:	few hives, mild itch	[ ] epinephrine & 911	[ ] antihistamine
Skin:	many hives over body, widespread redness	[ ] epinephrine & 911	[ ] antihistamine
Other:		[ ] epinephrine & 911	[ ] antihistamine

[ ] **Repeat epinephrine** for symptoms lasting longer than _____ minutes after 1st dose

Which meals will the student eat from the school cafeteria (please circle)? **BREAKFAST LUNCH NONE**

The following must be completed by a licensed physician:

Does the student have a disability or life threatening food allergy requiring diet modification? ***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 mental impairment that substantially limits one or more life activity" including a life threatening food allergy.*** **Yes No (circle one please)**

Does the student have a prescription for an Epi-pen for a food allergy? Yes No (circle one please)

Medical Diagnosis:____

Major life activities affected by the disability:____

Food to be Omitted:

____ Peanuts/Tree Nuts ____ Fish/Shellfish ____Wheat*

____ Fluid Milk ____ All Dairy Products ____ All foods containing milk as an ingredient*(Ex. Breaded items dipped in Milk)

____ Eggs by themselves ____ All foods containing egg as an ingredient*(Ex. Baked goods)

____ Soy as a main ingredient (Ex. Soy milk, edamame, soy sauce) ____ All foods containing soy as a major ingredient*(Ex. Soy in Processed foods)

____ Other:____________________________________

***If student must omit milk or egg as an ingredient, soy as a minor ingredient, wheat, or has multiple food allergies, we may suggest a meal is brought from home or special modifications will be made to accommodate them to receive meals in the cafeteria.**

Accommodations Needed:

____ Nut free foods ____ Texture Modified – ***Only for student with a medical diagnosis of dysphagia***

____ Seafood free foods ____ Pureed ____ Mechanical Soft Ground

____ No Milk/Dairy ____ Mechanical Soft Chopped ____ Other: ______________

____________________________ ____________________________ (______) ______-________ ______/______/20_____
Printed name of HCP Signature of HCP Phone number Date

I agree with the recommendations of my child's HCP and authorize WISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate WISD employees for the current school year.

____________________________ ____________________________ (______) ______-________ ______/______/20_____
Printed Parent/Guardian Name Parent/Guardian Signature Phone Number Date

PLEASE RETURN TO SCHOOL NURSE

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