LISD Lewisville Independent School District
COMMITTED TO EXCELLENCE

Health Services
Melanie Vincelette, BSN, RN
Director
469-713-5206

Dear Parent/Guardian;

You have provided us with information that your student has been diagnosed with a **Life Threatening Food Allergy**. In order to develop and put a plan in place that keeps your student safe, the following forms and records are needed:

- **Allergy Action Plan – Requires a doctor's signature**
- **Student Information Sheet**
- **Emergency Medication Self-Carry Agreement – Used as indicated and requires a doctor's signature**

If your student will be eating meals prepared in the school cafeteria and substitutions are needed, this additional form is required before any modifications will be made:

- **Food Allergy Evaluation and Substitution Form – Requires a doctor's signature**

All of the above forms are attached. Please contact me as soon as possible to discuss your student's specific allergies and to arrange for medications to be administered at school. Referral to the 504 Committee may be indicated and it is important that we work together as quickly as possible to put a plan in place.

Thanks for your attention,

Tina Chulick, RN
Bluebonnet Elementary School
chulickt@lisd.net
469-948-2302 office
214-626-1799

LISD Allergy Action Plan for Elementary Students

Place Student's Picture Here

Name: _____ **D.O.B** ____ /_____ /_____

Campus: _____ **Grade:** _____ **Teacher**_____

Severe Allergy to: _____

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

Student history and warning signs: _____

MILD SYMPTOMS	
Skin:	a few hives, mild itching
Mouth:	itchy mouth
Stomach:	mild nausea or discomfort
Nose:	itchy, runny nose, sneezing

SEVERE SYMPTOMS	
Skin:	many hives all over, redness, swelling of face, eyes, or lips
Lung:	short of breath, wheezing, repetitive cough
Throat:	tight, hoarse, trouble breathing or swallowing
Mouth:	swelling of tongue and/or lips
Stomach:	vomiting, diarrhea, severe cramping
Heart:	pale, blue, faint, weak pulse, dizzy, confusion, loss of consciousness
Others:	anxiety, feeling bad, or feeling of impending doom

TREATMENT PLAN
(TWO CHOICES – PLEASE CHECK ONLY ONE):

☐ **Plan 1: For MILD SYMPTOMS:**

Mild symptoms from **MORE THAN ONE BODY AREA** (skin, mouth, stomach, or nose) are **TREATED AS SEVERE SYMPTOMS**!!! Give **EPINEPHRINE**.

Mild Symptoms from a **single** body area:

1. Give ***Antihistamine*** if ordered.
2. Stay with student and monitor for worsening symptoms.
3. If symptoms progress, **USE EPINEPHRINE** (treat as **SEVERE** symptoms).
4. Contact parent.

For SEVERE SYMPTOMS:

1. **INJECT EPHINEPHRINE IMMEDIATELY**.
2. **Call 911.**
3. Give ***Antihistamine*** and then **Inhaler** if ordered (and not already used).
4. 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.
5. If symptoms do not improve, or return, more epinephrine may be needed. See order if you need to repeat the dose and when dose is to be repeated.
6. Contact parent.

OR

☐ **Plan 2: Give Epinephrine immediately for ANY symptoms** *if the allergen was likely eaten:*

1. **INJECT EPHINEPHRINE IMMEDIATELY**.
2. **Call 911.**
3. Give ***Antihistamine*** and then **Inhaler** if ordered.
4. 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.
5. If symptoms do not improve, or return, more epinephrine may be needed. See order if you need to repeat the dose and when dose is to be repeated.
6. Contact parent.

ORDERED MEDICATIONS AND DOSES

Antihistamine* Brand:*
[ ] Benadryl or Diphenhydramine
[ ] Other: _____

***Antihistamine* Dose**:
[ ] **12.5 mg** [ ] **18.75 mg** [ ] **25 mg**
[ ] **31.25 mg** [ ] **37.5 mg** [ ] **43.75 mg**
[ ] **50 mg**

Nurses Notes: _____**mg =** _____

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

EPINEPHRINE Brand:
[ ] EpiPen [ ] Auvi-Q

[ ] If not improved, give second dose of Epinephrine in _____ minutes.

[ ] Student will not have second dose of Epinephrine at school. _____ Parent's Initials

Inhaler or Other
(e.g., inhaler-bronchodilator if asthmatic):

Brand: _____

Dosage: _____ Route: _____

Frequency: _____

Indication for use: _____

I request and authorize Lewisville ISD personnel to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer these medications. *This form is valid for one school year. Physician must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable to initiate treatment for transferring students. A signature is required to authorize the registered nurse and the prescribing physician to discuss and/or clarify the medication order and the student's response to the treatment plan.*
Elementary students are not permitted to transport medications. Unused medications not picked up at the end of the school year will be disposed of properly.

Physician Signature: _____ **Printed Name:** _____
Date: _____ **Office #:** _____ **Fax #:** _____
Address: _____

Parent Signature: _____
Date: _____

Revised 1/16 **EpiPen Expires:** _____ **Benadryl Expires:** _____ **Inhaler Expires:** _____

Student Name: _____ **D.O.B.**_____

Severe Allergy To: _____

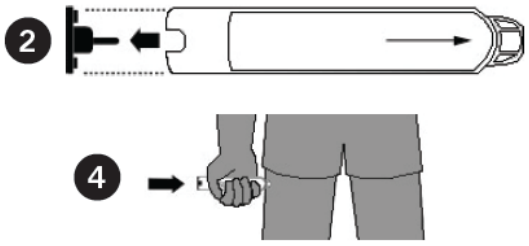
TREAT STUDENT BEFORE CALLING EMERGENCY CONTACTS

The first signs of a reaction can be mild, but symptoms can get worse quickly

THIS SIDE OF FORM TO BE COMPLETED BY SCHOOL NURSE	
WHEN THIS HAPPENS	DO THIS

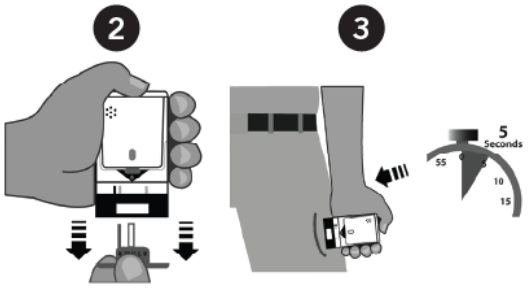
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



Emergency Contacts – CALL 911 FIRST

Rescue Squad: 911

Parent/Guardian: _____

Phone: _____

Other Emergency Contact: _____

Phone: _____

Doctor: _____

Phone: _____

Staff Trained on Student's Allergy Action Plan

Name & Date

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____ _____

Campus Nurse Signature Date

LIFE THREATENING ALLERGIES AND ASTHMA – STUDENT INFORMATION SHEET

Name: _____ Date of Birth _____ Date:_____

School: Bluebonnet Elementary School Teacher: _____ Grade: _____

Parent(s) Names (s): _____ Home Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

List and describe known allergies or suspected reactions to:

Foods/plants/others _____

Insects _____

Does he/she have allergies and/or asthma diagnosed by a doctor: Yes/No If yes, at what age? _____

Do you have a prescribed management plan? Yes/No If yes, please include a copy.

Has your child ever been hospitalized with an allergic reaction and/or asthma? Yes/No Last visit:_____
Has your child ever been treated in the ER with an allergic reaction and/or asthma? Yes/No Last visit_____
If yes, to either question, please describe:

_____

_____

Describe a typical allergic reaction and/or asthma attack:

_____

_____

What usually causes a reaction or an asthma attack?_____

_____

What usually helps if a reaction or an asthma attack occurs?

_____

_____

Usual Daily Medications (name, dose, times): _____

_____

Medications given frequently, but not daily? _____

_____

Describe side effects your student experiences from these medications? _____

_____

Does he/she know how to administer own medications? _____

Lewisville ISD Health Services
Emergency Medication Self-Carry Agreement

This plan is in accordance with HB 1688 from the 2001 Texas Legislative Session. This bill allows students to self-administer emergency rescue medication while at school or school functions with permission from parents, physicians, and the school nurse. This form is good only for the current school year and must be completed at the beginning of every school year.

Student Name: Grade DOB

Address:

Parent/Guardian: Phone# Phone#

Emergency Contact: Phone# Phone#

Treating Physician: Phone#

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY STATE OF TEXAS

☐ I have instructed _____ (student's name) in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the following emergency rescue medication while on school property or at school-related events:

Rescue Medications

Name:	Purpose:
Dosage:	When to Use:
Name:	Purpose:
Dosage:	When to Use:

For asthma inhalers only! **May repeat for severe breathing difficulty ____ times ___minutes apart.**

Physician's Signature _____ **Date:** _____

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her emergency rescue medication while on school property or at school related events according to school district policy and the student agreement below:

Parent/Guardian Signature _____ **Date:** _____

C. TO BE COMPLETED BY STUDENT AND SCHOOL NURSE

____ Student knows name, correct dosage, purpose, expected effects and side effects of medication.
____ Student demonstrates correct use/administration of medication.
____ Student understands that medication must have prescription label affixed, that authorization from the school nurse must be carried, that allowing anyone else to use this medication will result in disciplinary action, and that the PRIVILEGE of carrying this medication can be rescinded for violating any part of this agreement.

Student will carry/keep medication_____
Specify location

_____ _____ _____

Student Signature School Nurse Signature Date

Food Allergy Evaluation and Substitution Form

Student's Name		Age
Name of School Bluebonnet Elementary School	Grade Level	Classroom
Does the student have a life threatening allergy?	Yes ☐	No ☐
If yes, please describe the major life activity affected by the allergy. *Examples of these include: eating, breathing, walking, speaking*		
Does the student require substitutions or modifications to the normal school meals?	Yes ☐	No ☐
If yes, please have your Physician complete the form in its entirety. If no, please sign and send back to your school nurse.		

List Allergen(s)	List Foods to be Omitted	List Foods to be Replaced (Brands, Store)

Please list any supplemental feeding necessary: Contact Information:	
Parent or Guardian Name: Telephone: E-mail:	
Parent Signature:	Date:
Physician or Medical Authority Signature:	Date:

For Office Use Only:

☐ Recommended to 504 ☐ 504 in place ☐ No 504 needed