HEALTH SERVICES
Prosper Independent School District

Anaphylaxis Emergency Action Plan

*This form is valid only for the current school year.

Student Name: _____ DOB: _____/_____/_____ Weight: _____lbs.

SEVERE ALLERGY TO:_____

PROSPER ISD INTERNAL USE **Asthma**: ☐ **Yes** (higher risk of severe reaction) ☐ No
Student has DISTRICT authorization to self-administer: **Epinephrine auto-injector:** ☐ Yes ☐ No **Inhaler:** ☐ Yes ☐ No
Location of student's medications: _____

TO BE COMPLETED BY THE PHYSICIAN:

The parent/guardian has notified the school that this student has a potentially life-threatening allergy and will require epinephrine at school, in the event of an emergency. Please complete this form based on your examination and knowledge of this student and sign in the spaces provided (multiple pages).

What type of exposure triggers this student's allergic reaction? ..... ☐ Ingestion ☐ Contact ☐ Inhalation ☐ Bite/Sting

Extremely reactive to the following allergen: _____
THEREFORE:
☐ If checked, give: ☐ epinephrine ☐ antihistamine immediately for ANY symptoms if ***likely*** exposed to the allergen (by means of above trigger).
☐ If checked, give: ☐ epinephrine ☐ antihistamine immediately if was ***definitely*** exposed to the allergen (by means of above trigger), EVEN IF NO symptoms are noted.

Any of the following SEVERE SYMPTOMS:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faintness, weak pulse, dizziness
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Significant swelling (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

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications. *
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS:

NOSE:	Itchy or runny nose, sneezing
MOUTH:	Itchy mouth
SKIN:	A few hives, mild itch
GUT:	Mild nausea or discomfort

For **mild symptoms** from **more than one** system area, **give epinephrine**, call 911, and begin monitoring.

For **mild symptoms** from a **single** system area:
1. Give antihistamine.
2. Stay with student; alert school nurse & parent
3. If symptoms worsen, GIVE EPINEPHRINE.
4. Begin monitoring (see box below)

MEDICATIONS/DOSES

Epinephrine (brand): _____ Epinephrine Dose: ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg
Antihistamine (brand): _____ Antihistamine Dose: _____mg
Other (e.g., inhaler-bronchodilator if asthmatic): _____

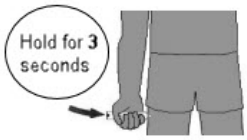
MONITORING
Stay with the student! Alert the school nurse and parent. Tell EMS epinephrine was given; request an ambulance with epinephrine. Note the time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, position student lying flat on their back, with their legs raised (as tolerated) & keep warm.

HOW TO USE AUVI-Q®

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

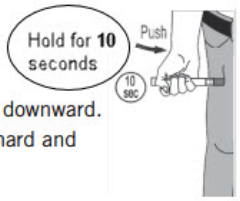
HOW TO USE EPIPEN®. EPIPEN JR® AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®)

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



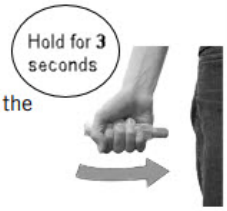
HOW TO USE IMPAX (AUTHORIZED GENERIC OF ADRENACLICK®)

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN®

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

PHYSICIAN PERMISSION FOR SELF-CARRY & SELF-ADMINISTRATION

Has this student been trained in the signs and symptoms of both mild and severe reactions? ..... Yes No
Regarding the **epinephrine auto-injector** :Is this student capable of self-administration & have they been trained how & when to do so?... Yes No
Regarding the **inhaler** : Is this student capable of self-administration & have they been trained how and when to do so?..... N/A Yes No
Does this student need the supervision of a designated adult? ..... Yes No
Does this student have physician permission to self-administer the **epinephrine** & to carry it on himself/herself?..... Yes No
Does this student have physician permission to self-administer the **inhaler** & to carry it on himself/herself?.....N/A Yes No

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Emergency Contact Information

Relationship	Name	Primary Phone	Alternate Phone
Mom/Guardian:			
Dad/Guardian:			

	Name	School Phone		Name	School Phone
School Nurse:			RN Partner:		

TO BE COMPLETED BY THE PARENT/GUARDIAN ----------

When was your child's FIRST reaction to their allergen? _____

When was your child's MOST RECENT reaction to their allergen? _____

In regard to their MOST RECENT reaction: Did your child recognize that they were having a reaction? ☐ Yes ☐ No

What were the circumstances surrounding the reaction? _____

_____

What specific symptoms did your child have during this reaction? _____

_____

What was your child's emotional response after the reaction? _____

My child: ☐ Rides the bus to/from school ☐ Participates in a school sponsored extracurricular activities/club: _____

Please rate the level of understanding you feel your CHILD has regarding his/her allergy:

Knowing what he/she is allergic to ……..…….. ☐ Minimal ☐ Some ☐ Good
Identifying items that might contain their allergen(s) ……..... ☐ Minimal ☐ Some ☐ Good
Possible symptoms of a reaction (minor and severe) …… ☐ Minimal ☐ Some ☐ Good
Knowing when to use antihistamine and/or inhaler vs. when to use epinephrine …… ☐ Minimal ☐ Some ☐ Good
How to use their epinephrine device …… ☐ Minimal ☐ Some ☐ Good

Note: If food substitutions are required for your child in the school cafeteria, please contact Child Nutrition. It is the responsibility of the parent/guardian to work with the campus administrator, school nurse, and classroom teacher regarding food during snack times, class parties, and/or on field trips. Prosper ISD cannot guarantee that foods brought from an outside source have been made without allergen products or contact with these products. A link to the Texas *Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis* is available on the Health Services page of the PISD website.

Consent for Severe Allergy Related Medications to be Administered at School

I, the parent/guardian of _____ request that PISD staff administer the medications prescribed by my provider in my Student's allergy action plan, to my Student (or that it be permitted for use in the school setting by my Student with current school year self-carry permissions also on file). I give permission for PISD staff to contact the prescribing provider and pharmacy for additional information regarding this medication, if needed. I agree to pick up unused, discontinued, or expired medication and understand that medications not picked up will be disposed of at the end or the school year or within two weeks after the medication expires or is discontinued, whichever is earlier.

☐ **Epinephrine**: _____ **Amount to be Given**: _____mg **Route**: IM injection **Expiration Date** : _____

☐ **Antihistamine**: _____ **Amount to be Given**: _____mg (= _____) **Route**: By Mouth
Expiration Date : _____

☐ **Inhaler**: _____ **Amount to be Given**: _____ puffs ☐ for wheezing or shortness of breath ☐ before exercise
Route: Inhalation **Expiration Date** : _____

I understand that while the campus maintains a limited supply of unassigned epinephrine for individuals experiencing symptoms of anaphylaxis, it is my responsibility to provide the prescribed medications to the school in order for the treatment prescribed by my physician to be provided by PISD, especially during off-campus activities where unassigned medications are not available. I understand that school administration will designate trained staff to perform this procedure. I will notify the school immediately if the health status of my child changes, I change physicians, or this plan is canceled or changed in any way. I give my permission for school staff to contact the prescribing provider listed above for additional information related to my child's allergy plan as needed, and consent to the release of those allergy related health records.

Parent's Signature: _____ **Date**:_____

OPTIONAL **PARENT PERMISSION FOR STUDENT TO CARRY & SELF-ADMINISTER EPINEPHRINE AND/OR INHALER**

I, the parent/guardian of _____ request that he/she be allowed to carry & self-administer the

☐ EPINEPHRINE AUTO-INJECTOR ☐ INHALER. My child and I have discussed, and agree, that my child will promptly alert PISD staff regarding symptoms and treatment so that appropriate follow-up care can be provided. I understand that school administration will designate trained staff to monitor the procedure (as made aware of signs/symptoms by the student). I understand that this medication must be stored in a properly labeled container (which includes the prescription label) at all times. PISD reserves the right to require that this medication be kept in the clinic if, in the school nurse's judgment, my child cannot or will not carry the medication in a safe manner or properly self-administer the medication.

Parent's Signature: _____ **Date**:_____

INTERNAL USE ONLY----------

Epinephrine:RN Initial Review:_____ ☐ Skyward MAR **Antihistamine**: RN Initial Review:_____ ☐ Skyward MAR

Inhaler: RN Initial Review:_____ ☐ Skyward MAR RN Reviews: _____ / _____ / _____ / _____