

**SHERMAN INDEPENDENT SCHOOL DISTRICT
ALLERGY ACTION PLAN**

Student's Name: _____
 Allergy to: _____
 Date of Birth: _____ Grade _____ Teacher: _____
 Asthmatic: Yes* *Higher risk for severe reaction
 No

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

I, the parent of _____ (student's name) agree with his/her physician to allow _____ (student's name) to carry his/her Epipen/Twinjet. Upon doing this, I realize that the school clinic will not have his/her personal Epipen/Twinjet unless I supply the school with an extra one in case my child forgets his/hers.

<p>For Self - Administration Only</p> <p>Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself? Yes ___ No ___</p> <p>Has this student been trained in the signs and symptoms of minor and major reactions? Yes ___ No ___</p> <p>Is this student capable of self-administering EpiPen/Twinjet? Yes ___ No ___</p> <p>Can this be safely self-administered in the school setting? Yes ___ No ___</p> <p>Does this student need the supervision of a designated adult? Yes ___ No ___</p> <p>Has the student been trained in the self-administration of the EpiPen/Twinjet? Yes ___ No ___</p> <p>Nurse Signature _____</p>

<p>Signs of an Allergic Reaction</p> <p>MOUTH..... itching and swelling of the lips, tongue or mouth</p> <p>THROAT itching and/or a sense of tightness in the throat, hoarseness and hacking cough</p> <p>SKIN hives, itchy rash, and/or swelling about the face or extremities</p> <p>LUNG shortness of breath, repetitive coughing, and or/wheezing</p> <p>HEART "thready" pulse, "passing out"</p> <p>GUT nausea, abdominal cramps, vomiting, and/or diarrhea</p>

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION:

- If only symptom (s) are: _____
 give _____
medication/dose/route
- Call Mother: _____ Father: _____
 or emergency contact _____

**IF CONDITION DOES NOT IMPROVE WITHIN 10 MINUTES,
FOLLOW STEPS 1-3 OF ACTION FOR MAJOR REACTION**

ACTION FOR MAJOR REACTION:

- If ingestion is suspected, and/or symptom (s) are: _____
immediately give _____
medication/dose/route
- Call EMS
- Call Mother: _____ Father: _____
 or emergency contact: _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMERGENCY MEDICAL SERVICES EVEN IF PARENTS CANNOT BE REACHED.

 Parent/Guardian's Signature

 Doctor's Signature

 Date

 Doctor's Phone #

 Date

Sherman Independent School District

Emergency Medical Response

Physician Delegation of Rescue Drug – Epi-pen

I have prescribed an Epi-pen for the student named below for use on an as-needed basis. In recognition of the need to administer this drug while in attendance at Sherman Independent School District, when a trained medical professional may not be available, I delegate the authority to administer the drug to unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse, with the signed approval of the parent. Further, I delegate the authority to a medical professional identified by the Sherman ISD to train UAPs to comply with this delegation, pursuant to §225.1 *et seq.* of the Regulations for the Nursing Practice Act.

Signature of ordering physician _____ Date _____

Printed name of physician _____

Student _____ Grade _____

Signature of parent _____ Date _____