

**McKinney Independent School District  
School Health Services**

Attach  
Photo

**Individualized Health Plan, Life Threatening Allergy**

Reviewed & accepted as IHP for current school year only. RN signature/date \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Severe Allergy to: \_\_\_\_\_ Has your child ever had a reaction? Yes  No

What was/were signs and symptoms of the reaction? \_\_\_\_\_

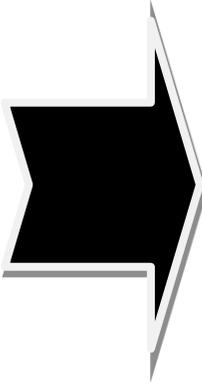
Asthmatic: Yes  No  \*\* Higher risk for severe reaction\*\* Medication expiration date(s): \_\_\_\_\_

**Any SEVERE SYMPTOMS after suspected or known allergen:**

Lung: Shortness of breath, repetitive coughing, wheezing  
 Heart: Thready pulse, low blood pressure, fainting, pale, blueness  
 Throat: Tightening of throat, hoarseness, hacking cough  
 Mouth: Itching, tingling or swelling of lips, tongue, mouth  
 Skin: Many hives all over the body

Or **Combination** symptoms from different body areas:

Skin: Hives, itchy rashes, swelling  
 Gut: Vomiting, crampy pain



**INJECT EPINEPHRINE IMMEDIATELY**

--Call 911  
 --Begin Monitoring (see below)  
 --Additional medications  
     \*\* Antihistamine  
     \*\* Inhaler (bronchodilator) if Asthma

*\*\*Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)*

*\*\*When in doubt, use Epinephrine. Symptoms can rapidly become more severe*

**MILD SYMPTOMS only**

Mouth: Itchy Mouth  
 Skin: A few hives around body, mouth/face, mild itch  
 Gut: Mild nausea/discomfort



**GIVE ANTIHISTAMINE**

--Stay with child, alert campus nurse and parent

**--IF SYMPTOMS PROGRESS (see above) INJECT EPINEPHRINE**

Yes  No give epinephrine for ANY symptoms if the allergen exposure was likely exposure  
 Yes  No give epinephrine before symptoms occur if allergen exposure was definite

**Call 911 and front office/campus nurse. Stay with student. Tell rescue squad epinephrine was given. Send the used epinephrine pen with EMS/911. A second dose of epinephrine can be given 5-15 minutes after the first injection if symptoms persist or reoccur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.**

**Medications provided by parent:**

**Epinephrine(name/brand):** inject intramuscularly \_\_\_\_\_  
 (See package insert for directions) **Once Epinephrine has been given, 911 must always be called!!!**

**Antihistamine:** give \_\_\_\_\_  
 Medication/dose/route Location of medication

**Other:** give \_\_\_\_\_  
 Medication/dose/route Location of medication

Student may self carry epinephrine  Student may self administer epinephrine **(LTA-Carrying Self-Injectable Epinephrine form must be completed)**

Printed Physician's Name Physician's Signature Physician's Number Date

Printed Parent Name Parent Signature Initials Date

**McKinney Independent School District  
School Health Services**

Student's Name: \_\_\_\_\_ ID \_\_\_\_\_

**After EMS notified**

- Gather accurate information about the reaction, including medical intervention and who witnessed the event.
- Save food eaten before the reaction or insect if possible, place in bag and save for analysis
- If food was provided by school cafeteria, review food labels with the cafeteria manager
- Follow up:
  - Review facts of the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student on a need to know basis.
  - Explanations should be age appropriate.
  - Amend and review the IHP, HCIS and/or 504 plan as needed after a reaction

Does your child know what allergens to avoid? Yes No

Does your child recognize symptoms of his/her allergic reaction? Yes No

Will you be providing meals for your child at school? Yes No

Will your child eat the school provided breakfast and/or lunch? Yes No

*\*\*If specific substitutions are required please have your physician complete the Dietary Accommodation Request Form\*\**

**PLEASE NOTE: All food produced or served on our serving lines are peanut-, tree nut-, and shellfish-free. Some Ala-carte snacks may be processed in a facility where nuts are present.**

**Classroom Parties, Field trips and Snacks:**

Classroom party dates and party options are specified by the campus administrator. Snack times are specified by the classroom teacher. **McKinney ISD cannot guarantee that the foods brought from an outside source have been made without allergen products.** You may choose to supply an alternative snack for your child.

**It is the parent of the child with allergies responsibility to work with the administrator, campus nurse, and classroom teacher regarding snack time, class parties, and field trips.**

**Lunch:**

If your child has a Life Threatening Food Allergy, MISD is attempting to add a layer of protection for your child in the cafeteria during the lunch period.

I DO \_\_\_ or DO NOT \_\_\_ wish for my child to sit at a lunch table specifically designated for children in my child's grade who may also have a similar life threatening food allergy.

***I understand and accept*** that this may mean that my child will sit at a table by him or herself during the lunch period if there are no other children with similar life threatening food allergens in their grade who have requested to sit at the designated allergen free table.

***I understand and accept*** that MISD employees will NOT check student's lunches to determine if they are "Peanut and other allergen free".

\_\_\_\_\_  
Printed Parent Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

**McKinney Independent School District  
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Student's Name: \_\_\_\_\_ ID \_\_\_\_\_

Student/Family Goals for this School Year:

Student will increase self-management as evidenced by:

1. \_\_\_\_\_ Date of Completion \_\_\_\_\_
2. \_\_\_\_\_ Date of Completion \_\_\_\_\_

**Emergency Contacts**

**Parent/Guardian** \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Other Emergency Contacts:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**School Clinic Number:** \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

I understand my child may be eligible for 504 accommodations. Please initial one of the following.

- \_\_\_\_ I am interested in learning more about 504 accommodations.
- \_\_\_\_ My student is already serviced by 504 accommodations. The last 504 meeting date was \_\_\_\_\_.
- \_\_\_\_ I am not interested in pursuing 504 accommodations at this time.

I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.

I request that this medication be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.

*I consent to the release of medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education and Privacy act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).*

\_\_\_\_\_  
Printed Parent Name                      Parent Signature                      Initials                      Date

**The following medication was destroyed due to failure to pick up the medication prior to the last day of school, medication was discontinued or medication was picked up by parent:**

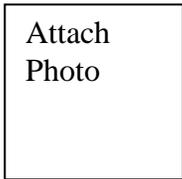
Medication amount disposed \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

RN Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

**OR**

Medication amount picked up \_\_\_\_\_ Parent signature and date \_\_\_\_\_

**McKinney Independent School District  
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**Health Condition Information Sheet**  
(For general staff use, copy and distribute as needed)

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Condition \_\_\_\_\_ Grade \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Parent's Name(s) \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Street Address \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Employer \_\_\_\_\_ Cell/Mobile # \_\_\_\_\_  
  
Emergency Contact #1 \_\_\_\_\_ Phone # \_\_\_\_\_  
Emergency Contact #2 \_\_\_\_\_ Phone # \_\_\_\_\_

If signs or symptoms of the above condition are noted please take the following steps:

- A) If this happens: \_\_\_\_\_  
Then do this: \_\_\_\_\_
- B) If this happens: \_\_\_\_\_  
Then do this: \_\_\_\_\_
- C) If this happens: \_\_\_\_\_  
Then do this: \_\_\_\_\_

Please circle one of the following to indicate the level at which this student can perform this care.

Independently                      Needs Assistance/Supervision                      Cannot do for self

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The IHP has been reviewed and discussed by the school nurse &/or parent/guardian & have listed the above information as staff awareness and individualized student information to expedite the care of the student during times when a school nurse may not be readily available. **This form may also be completed by the campus RN when information from the physician or parent has not been received and a teacher/substitute teacher needs to be advised of a medical condition & steps to ensure safety during times when a school nurse may not be readily available.**

School RN's Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Optional Parent Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Optional MD Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_