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
School Health Services

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_____

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School Health Services

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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: _____