Klein ISD Allergy Action Plan

Student Name: _____ **School Year: 20__ - 20__**
Date of Birth: _____ **Campus:** _____
Student ID: _____ **Bus #:** _____

Place Child's Photo Here

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction.

♦STEP 1: TREATMENT♦

Symptoms	Give Checked Medication** **To be determined by physician authorizing treatment.	
• If a food allergen has been ingested, but *no symptoms.*	Epinephrine	Antihistamine
• Mouth – Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
• Skin – Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
• Gut – Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• Throat† - Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
• Lung † - Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
• Heart † - Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
• Other † - _____	Epinephrine	Antihistamine
• If reaction is progressing (several of the above areas affected), give:	Epinephrine	Antihistamine

† Potentially Life-threatening. The severity of symptoms can quickly change.

DOSAGE:
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: **Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

♦STEP 2: EMERGENCY CALLS♦

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr._____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency Contacts:
   - Name/Relationship — Phone Number(s)

   a. _____ _____ _____

   b. _____ _____ _____

EVEN IF PARENT CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ **Date** _____

Physician's Signature _____ **Date** _____
(Required)

KLEIN INDEPENDENT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

STUDENT:_____ DATE OF BIRTH:_____

In an effort to promote student health and maintain school performance, it is necessary that medication be given during school hours.

Physician's request for giving medication(s) during school hours:

NAME OF MEDICATION	DAILY DOSAGE	SCHOOL DOSAGE	TIME TO BE GIVEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Comments: (Reason for medication, possible side effects, etc.)

_____

_____

*No injections may be given except those needed in emergency situations or those necessary for the student to remain in school (i.e. insulin, epinephrine).

Physician's Signature: _____ Date: _____

Physician's Name (**Please Print**): _____Phone: _____

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Klein school personnel are not permitted to give medication of any kind, including aspirin, similar preparations, or any other drugs, unless the parent requests in writing that there is a need for such medication. Non-prescription medications needed for longer than two weeks must also have a written request from a physician. When administering prescription medicines, the school district would prefer to have a written statement from a physician or dentist licensed to practice in the United States. Information, however, placed on a prescription label, if it is precise and clear to the school nurse, may be substituted for the above noted statement. The prescription must be filled by a pharmacist licensed to practice in the United States. All medications must be in their original container and kept in locked storage in the office of the nurse or principal's designee and administered by the nursing staff or a school employee. If the circumstances are questionable, the school employee reserves the right to deny the parent's request. No vitamins, health food or herbal preparations will be given by any school employee. Neither prescriptions nor over the counter medications from foreign countries will be administered.

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PARENT/GUARDIAN AUTHORIZATION

I hereby authorize school personnel to administer non-prescription medication to my child during school hours or prescription medication as prescribed by the physician. I understand that any non-prescription medication that is to be dispensed to my child longer than two weeks will also need a doctor's authorization. Also, I am aware that no medication dosage will be changed without an order from the prescribing physician.

I (do / do not) authorize school personnel, at my oral request, to administer dosages of medication in addition to the dosages specified on this form, if necessary for my child to receive the daily dosage prescribed by his or her doctor and specified on this form. If I make such a request, I shall ensure that I provide the school with additional medication thereafter to enable the school to continue making the scheduled school dosages

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: _____

Item No. 19.5550
Revised 1/26/95, atty.
Updated 8/28/01 atty.

KLEIN INDEPENDENT SCHOOL DISTRICT
NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name: DOB: School:

We are requesting that you authorize Klein ISD (or its agent) to speak with the party specified regarding the above-named student and the release or request of specified records containing confidential information regarding the above-named student.

☐ KLEIN I.S.D. HAS PERMISSION TO RELEASE INFORMATION TO:

Name: Phone:

Address:

City: State: Zip:

☐ KLEIN I.S.D. HAS PERMISSION TO REQUEST INFORMATION FROM:

Name: Phone:

Address:

City: State: Zip:

RECORDS REQUESTED
- ☐ All Educational Records
- ☐ Transcript & Immunizations
- ☐ Academic Assessments
- ☐ Psychological Assessment
- ☐ Comprehensive Assessment
- ☐ Speech/Language Assessment
- ☐ Vocational Assessment
- ☐ OT/PT Assessments
- ☐ Medical Reports
- ☐ ARD/EP Reports
- ☐ Individual Translation Plans
- ☐ Other: _____

PURPOSE OF DISCLOSURE:
☐ Health Planning ☐ Educational Planning ☐ Student Transfer ☐ Other:

If you wish to have more information or if you have any questions, please contact the following staff person:

Name: Phone:

__Yes __No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.

__Yes __No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of the signature.

Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of the child or the provisions of a free appropriate public education.

_____ Date: _____
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_____ Date: _____
Signature of Interpreter, if used

Please return to: Name Date Mailed/Sent: Address
City/State/Zip