INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH FOOD AND LIFE-THREATENING ALLERGIES 2024-2025 SCHOOL YEAR

To be completed by the Parent:

Student Name: _____ Grade: _____

Allergies to: _____

Student needs to avoid: _____

Reaction(s) student has: _____

Self-Carry permission from a physician: ☐ **NO** ☐ **YES ***

*****If **YES,** the parent will complete the ***Self-Carry and Self-Administer Epinephrine Auto-Injector*** agreement.

EMERGENCY CONTACTS	OTHER EMERGENCY CONTACTS
PARENT/GUARDIAN:_____	NAME:_____
PHONE:_____	PHONE:_____
DOCTOR: _____	NAME:_____
PHONE:_____	PHONE:_____

_____ (Student Name) has severe allergies as mentioned above and in the Individualized Health Care Plan from the physician. I have provided the school with the physician's medication permission and instructions. I am requesting these instructions be carried out by the school. I have instructed my child about his/her allergy and how to avoid exposure to the allergen, care to take if exposure occurs and tell an adult immediately if they have encountered the allergen or are having a reaction. I will provide the medication with a proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request the medication specified by the physician be given to the above-named student, and it may be administered by medical or non-medical personnel. I understand 911 is called with the use of Epinephrine.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston-Houston, its servants, agents, and any employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive all claims, demands, or causes of action against the Archdiocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication. It is mutually understood that the Archdiocese and its employees and affiliates are immune, pursuant to Tex. Educ. Code §38.215, from suit resulting from any act or failure to act concerning the administration of epinephrine medication under the individualized health care plan for food and life-threatening allergies. Nothing within this Agreement shall be interpreted to waive this immunity.

Parent Signature: _____ Date:_____

To be completed by School:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature:_____ Date:_____

Before & After Program Coordinator Signature: _____ Date: _____
(If applicable)

Teacher notification provided by: _____ Date: _____

- School staff may be notified of the student's health condition and the treatment plan in case of an emergency.

INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH FOOD AND LIFE-THREATENING ALLERGIES
2024-2025 SCHOOL YEAR

To be completed by the Physician:

Students Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____lbs. **Asthma:** ☐ *** YES (higher risk for a severe reaction)** ☐ **NO**

NOTE: Treat the person before calling emergency contacts. The first sign of a reaction can be mild, but symptoms can worsen quickly.

Extremely reactive to the following allergens: _____

THEREFORE: ☐ If checked, give Epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give Epinephrine immediately if the allergen was Eaten, even if no symptoms are apparent.

SEVERE SYMPTOMS

FOR **ANY** OF THE FOLLOWING FOLLOW DIRECTIONS BELOW

LUNG

Shortness of breath, wheezing, repetitive cough

HEART

Pale or bluish skin, faintness, weak pulse, dizziness

THROAT

Tight or hoarse throat, trouble breathing or swallowing.

MOUTH

Significant swelling of the tongue or lips

SKIN

Many hives over body, widespread redness

GUT

Repetitive vomiting, severe diarrhea

OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION

of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
3. Consider giving additional medications following epinephrine:
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert Emergency Contacts.
7. Transport patient to ER, even if symptoms resolve.

MILD SYMPTOMS

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW

NOSE

Itchy Runny nose
Sneezing

MOUTH

Itchy mouth

SKIN

A few hives
Mild itch

GUT

Mild nausea or discomfort

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person, **ALERT** Emergency Contacts.
3. Watch closely for changes. If symptoms worsen, give **EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic:

_____

Antihistamine Dose: _____

Other (inhaler-bronchodilator if wheezing):

_____

May Self-Carry Epinephrine**:** **YES** **NO**

May Self-Administer: **YES** **NO**

Physician initial: _____ The above student has demonstrated the proper use of his/her Epinephrine. I have instructed the student in the correct and responsible use and confirm that the student can carry and administer the prescribed Epinephrine.

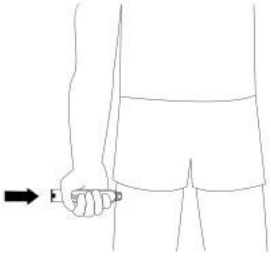
PHYSICIAN SIGNATURE **PRINT** **PHONE NO.** **DATE**

EPIPEN® AND EPIPEN JR® (EPINEPHRINE) Directions:

EpiPen 2-Pak® EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

1. Remove Auto-Injector from the clear carrier tube.
2. Pull off the blue safety release by pulling straight up.

3. Hold the orange tip near the outer thigh (always apply to the thigh)

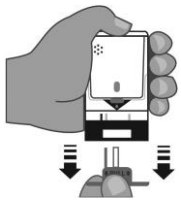


4. Swing and firmly push orange tip against outer thigh. Hold on thigh firmly for approximately 3 seconds.
   (Count slowly 1, 2, and 3).
5. Remove and massage the injection area for 10 seconds.
6. **Call 911** and get emergency medical help right away.

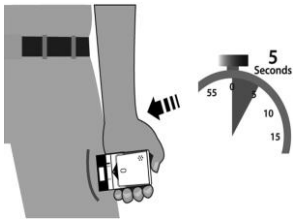
Auvi-Q (EPINEPHRINE) Directions:

Auvi-Q
epinephrine injection, USP
0.15 mg/**0.3 mg** auto-injectors

1. Remove the outer case of AUVI-Q. This will activate the voice instructions.
2. Pull off the RED safety guard.



3. Place the black end against the outer thigh, press firmly, and hold for 5 seconds.



4. **Call 911**

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. **Call 911** immediately after injection

Adrenaclick (EPINEPHRINE) Directions:

ADRENACLICK®
(epinephrine injection, USP) auto-injector

1. Remove GREY caps labeled “1” and “2”

2. Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds then remove.
3. **Call 911**

Source: Food Allergy Research & Education (FARE) (WWW.FOODALLERGY.ORG) 5/2014

SELF-CARRY AND SELF-ADMINISTER EPINEPHRINE AUTO-INJECTOR AGREEMENT
2024-2025 SCHOOL YEAR

To be completed by the Parent and Student:

Student name: _____ Date of Birth: _____

Where will the student carry the Epinephrine auto-injector (**required**): _____

An additional Epinephrine auto-injector will be provided to the school and stored with prescribed medication at a specified school location: (**required**): _____

STUDENT

- I will notify school personnel if I am having more difficulty than usual with my allergies.
- I agree to carry my Epinephrine auto-injector with me as listed above. If an emergency arises and I am unable to get to the nurse/school personnel, I will use the Epinephrine auto-injector as prescribed by the physician and then **immediately** inform a nurse/school personnel.
- I agree to use my Epinephrine auto-injector responsibly, following the physician's orders. I understand my life-threatening allergy, exposure, symptoms, and treatment plan reviewed by my physician and parent(s)/guardian(s) and understand to use my Epinephrine auto-injector only when an emergency arises, as prescribed by my physician, and I am unable to get to the nurse/school personnel in time.
- I agree to never share my Epinephrine auto-injector with another person as this is dangerous. If I do this may result in disciplinary action.

Student Signature: _____ Date: _____

PARENT/GUARDIAN

- I agree to see that my child carries his/her Epinephrine auto-injector as prescribed and that it is properly labeled and is not expired.
- I understand that I will provide the school with an additional Epinephrine auto-injector to store at school along with any prescribed medication(s) from the physician's treatment plan.
- I have reviewed with my child their life-threatening allergy, exposure, symptoms, and treatment plan including the usage of the self-carry Epinephrine auto-injector if an emergency arises.
- I agree to regularly review with my child the proper use of his/her Epinephrine auto-injector when at school.
- I agree to regularly review the status of my child's allergies with the physician and to notify the physician when my child is having more difficulty than usual.
- I understand if my child shares medication with other students it may result in disciplinary actions.
- My child has demonstrated to his/her physician and the school, nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication in case an emergency arises, and they are unable to get to a school personnel/nurse.
- The self-administration is done in compliance with the prescription or written authorization for my child to self-administer the medicine while on school property or at a school-related event or activity.
- I understand that such self-administration must be done in compliance with the prescription or written instructions of my child's physician. Additionally, I have provided a written and signed statement from my child's physician that states:
    1. The student has a life-threatening allergy and is capable of self-administering the prescription medicine.
    2. The name and purpose of the medicine; the prescribed dosage of the medicine; the times or circumstances in which the medicine may be administered; and the duration for which the medicine is prescribed.
- This is in effect for the current school year only unless revoked by the physician or the student, parent(s)/guardian(s) fails to meet all the above safety contingencies.

Parent Signature: _____ Date: _____