Allergy Action Plan

Attach Student's Photo Here

Student:_____ **D.O.B:**_____ **Teacher:**_____ **School:**_____

ALLERGY TO: _____ **Past Reaction Type:** _____

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*:	☐ Observe	☐ EpiPen	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
Throat *	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
Lung *	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
Heart *	Weak, thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
Other *	_____	☐ EpiPen	☐ Antihistamine
If Reaction is progressing (several of the above areas affected), give:		☐ EpiPen	☐ Antihistamine

****The severity of symptoms can quickly change. * Potentially life-threatening*

DOSAGE

Epinephrine: _____
Route to administer

☐ EpiPen 0.3mg ☐ EpiPen Jr. 0.15mg
☐ Twinject 0.3mg ☐ Twinject 0.15mg
☐ Auvi-Q 0.3mg ☐ Auvi-Q 0.15mg

Other medicine: _____

☐ Give a second epinephrine dose after_____minutes if no improvement and EMS has not arrived.

Antihistamine: _____
Medication / Dose / Route

Other Medication to administer: _____
Medication / Dose /Route / Reason for administration

STEP 2: EMERGENCY CALLS

1. **Call 911. Tell them that a child is having an allergic reaction and may need epinephrine when they arrive. After epinephrine has been given, lay the student flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.**
2. **Even if a parent/guardian cannot be reached, do not hesitate to medicate and have the student transported to the nearest medical facility. Transport to ER even if symptoms resolve.**

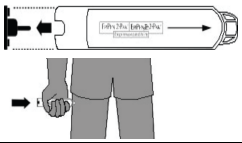
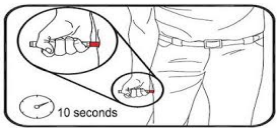
Parent/Guardian: _____/_____/_____/_____
Print **Signature** **Date** **Telephone Number**

Physician_____/_____/_____/_____
Print **Signature** **Date** **Telephone Number**

EMERGENCY CONTACTS

	Name	Relationship	Number(s)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

DIRECTIONS

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS	AUVI-QTM (EPINEPHRINE INJECTION, USP) DIRECTIONS	ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS
1. Remove the EpiPen Auto-Injector from the plastic carrying case. 2. Pull off the blue safety release cap. 3. Swing and firmly push orange tip against mid-outer thigh. 4. Hold for approximately 10 seconds. 5. Remove and massage the area for 10 seconds. 	1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions. 2. Pull off red safety guard. 3. Place black end against mid-outer thigh. 4. Press firmly and hold for 5 seconds. 5. Remove from thigh. 	1. Remove the outer case. 2. Remove grey caps labeled "1" and "2". 3. Place red rounded tip against mid-outer thigh. 4. Press down hard until needle penetrates. 5. Hold for 10 seconds. Remove from thigh. 

SELF-ADMINISTRATION OF PRESCRIPTION ANAPHYLAXIS MEDICINE

(To be completed by the Authorizing Physician)

☐ It is my professional opinion that _____ (student's name) ***should <u>NOT</u>*** be allowed to carry and self-administer any of his/her anaphylaxis medicine while on school property or at school related events.

☐ It is my professional opinion that _____ (student's name) ***should*** be allowed to carry and self-administer _____ while on school property or at school-related events. I have instructed the student in the proper way to self-administer the anaphylaxis medicine. The student is knowledgeable about the medicine and how to administer it.

_____/_____/_____

Physician (Print Name) **Signature** **Date**

(To be completed by Parent/ Legal Guardian)

<u>APPLICABLE ONLY IF THE CRITERIA HAS BEEN IS MET TO SELF-ADMINISTER PRESCRIPTION ANAPHYLAXIS MEDICINE</u>

I give permission for my student to self-administer the prescribed medication listed above, in accordance with the physician's order, while on school property or at a school-related event or activity. Self-administration must be done in compliance with the prescription and state law.

_____/_____/_____

Parent/Guardian (print) **Signature** **Date**

DALLAS TORAH CENTER
Preschool

DTC PRESCHOOL DIETARY ORDER FORM

Name: _____ DOB:_____

Physician Name: _____

Physician Phone: _____ Physician Fax: _____

Diagnosis/ Disability: _____

How does this handicap/disability restrict the child's diet? _____

_____

Major life activity affected by disability (circle all that apply): Eating Walking Seeing Hearing Speaking Hearing Speaking Learning Performing Manual Tasks Breathing

Dietary Prescription

Diet Order (specify calories, carbohydrates, sodium, etc): _____

Foods to omit due to allergies: Dairy Peanut Butter Wheat Eggs Citric Acid Other: _____

Food to be substituted: _____

Duration of time for special diet/restriction: _____Weeks _____Months _____Until end of school year

Textures allowed (circle all that apply): Ground Pureed Chopped Other Regular

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Below for physician office use only

I _____, (physician's name) declare the child listed above to possess the following life threatening food allergy.

1. *Life threatening food allergy- omit these foods (circle all that apply)*

   Milk Peanuts Tree Nuts Eggs Fish Shellfish Wheat Soy

2. *Can the student consume foods where the allergen is an ingredient in the food product? (Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed).*

   Yes No *Explain* _____

3. *Other life threatening food allergies- omit these foods (list all):* _____

_____

I certify that the above named child required nutritionally modified meals as described above due to the child's disability.

Signature of Physician: _____ Date: _____

Below for parent/guardian use only

I give permission for the school staff to follow the above nutrition plan.

Parent/Guardian Signature: _____ Date: _____

DALLAS TORAH CENTER
Preschool

DTC PRESCHOOL ASTHMA ACTION PLAN

Name: _____ DOB:_____

Physician Name: _____ Physician Phone: _____

Physician Fax: _____ Father Name:_____

Father Cell: _____ Mother Name:_____

Mother Cell: _____

BELOW PORTION TO BE COMPLETED BY PHYSICIAN

Asthma Medication	Dosage/ Method	Frequency	Possible side effects	Administer 15 min before phsyical activity	Length of time medications can be kept at school
				▢ Yes ▢ No	
				▢ Yes ▢ No	
				▢ Yes ▢ No	

EMERGENCY PLAN

1. _____ (medication) can be repeated for severe breathing difficulty _____ times, _____ minutes apart.
2. Call parent/legal guardian and/or 911 or EMS if minimal or no improvement.

SELF-ADMINISTRATION OF PRESCRIPTION ASTHMA MEDICINE

☐ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medications while on school property or at school related events.

☐ It is my professional opinion that _____ (student's name) should be allowed to carry and self-administer _____ (medication) while on school property or at school-related events. I have instructed the student in the proper way to self-administer the asthma medication(s). The student is knowledgeable about the medication(s) and how to administer it.

Physician's Signature: _____ **Date**: _____

BELOW PORTION TO BE COMPLETED BY PARENT/ GUARDIAN

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/ Guardian Name (Signature)** **Date**

When applicable, I give permission for my student to self-administer the prescribed medication listed above, in accordance with the physician's order, while on school property or at a school-related event or activity. Self-administration must be done in compliance with the prescription and state law.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/ Guardian Name (Signature)** **Date**

DALLAS TORAH CENTER
Preschool

DTC PRESCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

Name: _____ DOB:_____ Grade: _____

Physician Name: _____

Physician Phone: _____ Physician Fax: _____

According to the Texas Education Code and Torah Day School, all medications administered at school must comply with the following guidelines:

1. All medication(s) must be in its original/properly labeled container with written request, to administer, from the parent/guardian. The medication must be FDA approved with dosage information clearly marked on the container.
2. Medications kept at school for greater than 3 consecutive days will require written authorization from a licensed physician.
3. Only medications that cannot be given at home will be given at school.
4. No more than a 30 day supply of medication(s) will be accepted at a time.
5. Medication that has expired or is not picked up by the parent will be properly destroyed.
6. Trained Torah Day school employees may administer medication(s) when a nurse is not available.
7. Aspirin or products containing aspirin will not be given without a physician's order.
8. Medication(s) purchased in a foreign country will not be administered to students unless the pharmacy is a U.S. FDA approved pharmacy.

Medication	**Dose**	**Route**	**Time**	**Possible Side Effecs**	**Length of time to be administered**
Please list any and all diagnoses for which above medications are prescribed.					

Will this be the first dose of a new medication for the student? ▢ Yes ▢ No

FOR PHYSICIAN USE ONLY:

I authorize the medication(s) listed above to be kept at school and administered to the student as listed above.

_____ _____ _____

Physician Name (Print) **Physician Name (Signature)** **Date**

FOR PARENT/GUARDIAN USE ONLY:

I authorize that the above medication(s) be given to my child as directed. I hereby give permission to the school nurse to contact the prescribing physician with any questions related to the above medication(s) and diagnosis.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/ Guardian Name (Signature)** **Date**