Place Child's Picture Here

Katy Independent School District
Health Services Department

Allergy Action Plan

Transportation
□ Car Rider □ Walker
□ Bus #_____
□ Other: _____

Student has permission to transport medication listed below to and from school?
□ YES □ NO

Students Name	Date of Birth	Grade
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Allergy to:	Triggers:	

Asthma: ☐ Yes ☐ No *Higher risk for severe reaction

Sensitivity: ☐ Ingestion Only ☐ Topical/Ingestion ☐ Topical ☐ Airborne

Additional Details:	Yes	No	Comments
History of EpiPen use			
History of reaction			
Special lunch seating required			
Classroom accommodation needed			

STEP 1: TREATMENT

Symptoms:		Give Checked Medication**: (**To be determined by physician)
• 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,	□ 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.

	Name of Medication	Dose	Route
Antihistamine			
Epinephrine			
Other			
Other			

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

STEP 2: ANAPHYLACTIC EMERGENCY PROTOCOL

- Contact campus nurse at _____
- Administer emergency medications
- Call 911
- Notify parent or emergency contact
- Document episode/Student Accident Report Filed & complete Post Anaphylaxis Reaction Review
- Other: _____

I agree with the recommendations of my child's HCP and authorize Katy ISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate Katy ISD employees for the current school year.

Physician Name	Printed Name	Phone	Date
Parent/Guardian Signature		Date	

ADDENDUM to Action Plan

NURSE USE ONLY:

☐ Transportation Notified: Date Faxed _____

☐ Bus Driver Notified

☐ Added to Medical Alerts

☐ Self-Carry

☐ Diet Modification: Date Faxed _____

☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◊ TRAINED STAFF MEMBERS ◊ (To be completed by campus personnel)	
Teacher's Name:	**Date:**
Teacher's Name:	**Date:**
Administrator's Name:	**Date:**
Office Staff's Name:	**Date:**
Cafeteria Staff's Name:	**Date:**
Bus Driver's Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**

OTHER COMMENTS:

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____