Student Food Allergy Guidelines Update

Senate Bill 27 (82nd Legislative Session) requires that all school boards and the governing bodies of open-enrollment charter schools adopt and administer a policy for the care of students with diagnosed food allergy at risk for anaphylaxis. This must be done by August 1, 2012.

The University of Texas Elementary School has systems in place to monitor students with food allergies and communicate their needs with staff. The following items will be added to UTES food allergen protocol to achieve compliance with the new DSHS guidelines.

- Food Allergy Action Plan (for identified students)
- Emergency Action Plan
- Food Allergy Planning Charts
- Outline of Family, School and Student Roles
- Staff Roles and Responsibilities
- Considerations for Administrative Regulations
Anaphylaxis Management Protocol

1.) School Nurse will determine if there is a student with a history of risk of anaphylaxis on campus by reviewing:
   - Current school year student medical forms
   - Previous school year student medical forms
   - Previous school year IHCPs (Individualized Health Care Plans)

2.) School Nurse will schedule a meeting with parent or guardian of the student to determine:
   - Previous medical history
   - Type of level of care the parent is seeking for their child:
     - Epi-Pen kept in nurse’s office
     - Benadryl kept in the nurse’s office

3.) School Nurse will collaborate with student, parent/guardian and physician to:
   - Obtain medical orders for Benadryl and Epi-Pen to be administered at school as needed
   - Have Epi-Pens and Benadryl stored on campus per physician orders

4.) School Nurse will:
   - Prepare Individualized Health Care Plan
   - Notify appropriate school staff with a need to know of student’s condition including general education teachers, Special Areas teachers, Cafeteria staff, cafeteria monitors, administrative staff
   - Train designated staff on “Emergency Action Plan” and the use of the Epi-pen
   - Educate staff that “Emergency Action Plan” and medications must accompany student on all field trips or short outings
   - Provide retraining of staff as needed throughout the school year
   - After an event, a review will take place between the campus nurse and administrative staff to determine what went well and what needs to be improved in the process

Form is in compliance with SB27
University of Texas Elementary School
Food Allergy and Anaphylaxis Plan

Determine if student has a history or risk of serious food allergy or anaphylaxis while at school by reviewing student medical forms:

- Current Medical History Form
- Previous year’s Medical History Form
- Previous Year Medical History Form

Schedule a meeting with parent/guardian to determine level of care student will need while at school.

- Review medical history
- Acquire physician’s orders
- Anaphylaxis/allergy form from parent
- Parent authorization for medication
- MD order and parent authorization for self-administration
- Parent provides all supplies

Create Individualized Health Care Plan:

- Assess student
- Develop IHCP and give copy to appropriate faculty and staff
- Create Emergency Action Plan

Notify appropriate school staff

Train and document all trainings:

- Train designated staff on management of anaphylaxis
- Train staff on Emergency Action Plan and Epi-Pen
- Educate staff that Emergency Action Plan and medications must accompany student on field trips and outings
- Provide re-training of staff as needed throughout the school year

*Form is in compliance with SB27*
Dear Parents,

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the school in order to enable the school staff to take necessary precautions to insure your child’s safety.

“Severe food allergy” means a dangerous or life-threatening reaction of the human body to a food-borne allergen through inhalation, ingestion or skin contact that requires immediate medical attention.

Please list any food to which your child is allergic or severely allergic, as well as how your child reacts when exposed to the food that is listed.

- No information to report.

<table>
<thead>
<tr>
<th>Food</th>
<th>Nature of Allergic Reaction to Food (how child reacts)</th>
<th>Life-Threatening?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

TO REQUEST A SPECIAL DIET, MODIFICATION OF MEAL PLAN OR PROVIDE OTHER INFORMATION FROM YOUR DOCTOR ABOUT YOUR CHILD’S FOOD ALLERGY, YOU MUST CONTACT THE SCHOOL NURSE.

The University of Texas Elementary School will maintain the confidentiality of the information provided above and may disclose the information to teachers, café staff, transportation staff, administration and any other school personnel only within the limitations of the Family Educational Rights and Privacy Act and district policy.

Student Name: ____________________________________________ Date of Birth: ____________

Parent/Guardian Name: ____________________________________________

Work Phone: ________________ Mobile Phone: ________________ Home Phone: ________________

Parent/Guardian Signature: ______________________________________ Date: ____________

Date Form Received by School Nurse: ________________________
**The University of Texas Elementary School**

**Anaphylaxis/Allergy Emergency Action Plan**

**Student:** _________________________________________ is allergic to: ________________________.

1.) If you suspect that a food allergen has been ingested or a bee sting has occurred, immediately determine symptoms and treat the reaction as follows:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Give Medication checked with “X”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouth</td>
<td>Itching, tingling or swelling of lips, tongue, mouth</td>
</tr>
<tr>
<td>Skin</td>
<td>Hives, swelling of face or extremities, itchy rash</td>
</tr>
<tr>
<td>Gut</td>
<td>Nausea, abdominal cramps, vomiting, diarrhea</td>
</tr>
<tr>
<td>Throat</td>
<td>Tightening, of throat, hoarseness, hacking cough</td>
</tr>
<tr>
<td>Lung</td>
<td>Shortness of breath, repetitive coughing, wheezing</td>
</tr>
<tr>
<td>Heart</td>
<td>Thready pulse, passing out, faintness, pale, blueness</td>
</tr>
<tr>
<td>General</td>
<td>Panic, sudden fatigue, chills, fear of impending doom</td>
</tr>
<tr>
<td>If a food has been ingested, but student has NO symptoms</td>
<td>Benadryl</td>
</tr>
<tr>
<td>If a reaction is progressing (several of above areas have been affected)</td>
<td>Benadryl</td>
</tr>
</tbody>
</table>

**Medication Dosage**

Benadryl or other Antihistamine: Give _____ teaspoon(s), _____ cc, ______mg by mouth

Epinephrine/Epi-Pen: _____ mg injected into upper thigh

*Epinephrine injection may need to be repeated if reaction continues or worsens*

*Call 911 if symptoms continue or worsen after additional medication has been provided*

*State that the child has a severe allergic reaction, and additional epinephrine may be needed*

**Additional Contact Information:**

Nearest Hospital: ___________________________ Phone: ___________________________
Allergist Name: ___________________________ Phone: ___________________________
Pediatrician’s Name: ___________________________ Phone: ___________________________

Parent’s Name and Contact Information:

Name (1): ___________________________ Phone: ___________________________
Name (2): ___________________________ Phone: ___________________________
Name (3): ___________________________ Phone: ___________________________

*If any emergency contact’s phone number changes, please report new number to front office and nurse immediately*

**DO NOT HESISTATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED**

Physician’s Signature: ___________________________ Date: ___________________________

Parent’s Signature: ___________________________ Date: ___________________________
Parent/Guardian Authorization for Self-Administration of Inhaler or Epi-Pen at School
(one form must be completed for each medication)

Student Name: _________________________________________ Date of Birth: ________________
School: The University of Texas Elementary School Grade Level: ________________

Only those medications that are medically necessary during school hours for a student’s attendance or written in an IEP should be sent to school. UTES also requires the following:

- Medication is in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician who is licensed in Texas; current date). Epi-Pen must not be expired.
- Medication labels must include the student’s first and last names.
- All sharps are to be disposed of in an approved container.

Please complete the following:

<table>
<thead>
<tr>
<th>Medication Name and Strength</th>
<th>Dosage</th>
<th>Times to be Given at School</th>
<th>Additional Comments</th>
</tr>
</thead>
</table>

Medication Start Date: _________________ Medication Stop Date: _________________

- I request that the above medication be given during school hours as ordered by physician. I also request that the medication be given on field trips and outings as prescribed.
- I give permission for the school nurse to communicate with the student’s teachers about the student’s health condition(s) and the action(s) of the medication.
- I give permission for my child to carry a prescribed inhaler or Epi-Pen use it without supervision.
- I give permission for trained personnel to assist my child with an inhaler as needed.
- I have provided the following WRITTEN AUTHORIZATION FROM PHYSICIAN

I request that my child be provided authorization to carry a prescribed Epi-Pen or inhaler and to use it without adult supervision.

Parent Signature: _________________________________________ Date: _________________

Physician Authorization:

[  ] Student is knowledgeable about the asthma inhaler or Epi-Pen and how to use it safely.
[  ] Student may administer medication with adult supervision.

Physician’s Name: _________________________________ Office Phone Number: ______________

Physician’s Signature: _______________________________ Date: ________________________

Principal/Designee notified of self-carry ___yes ___no IHCP on file ___yes ___no

School Nurse Signature: _________________________________________ Date: ______________

Form is in compliance with SB27
Epi-Pen Competency Checklist for Unlicensed Personnel

Person Trained: ______________________________________________ Title: _____________________________

Trainer: _____________________________________________________ Title: _____________________________

How to Use an Epi-Pen:

1.) Pull off the safety cap.

2.) Place Epi-Pen tip hard against the out thigh. It should click when activated. Hold it in place for 10 seconds. It may be used through clothing.

3.) Remove Epi-Pen and massage area for 10 seconds.

4.) Student should be kept quiet and warm.

5.) Monitor student’s condition (Airway, Breathing and Circulation) and begin CPR if necessary.

6.) Call 911 immediately. Tell EMS that an Epi-pen was administered. (Epi-pen only lasts 20-30 minutes)

7.) Notify parents/guardian or emergency contact person.

8.) Discard used Epi-Pen in appropriate sharps container in nurse’s office.

I (trainer) _______________________________ have trained the person as orientee in steps and skills listed above.

Trainer Signature: ________________________________________________________ Date: _________________

I (orientee) _______________________________ understand all steps and skills performed above and will consistently perform them properly as trained. I understand that I am to page the School Nurse, call 911 or call the student’s parents/guardians if I have any questions about this procedure.

Orientee Signature: _______________________________ Date: _________________
Date: ___________________________   School: The University of Texas Elementary School

**Student Information**

Student Name: ___________________________   Date of Birth: ___________

Address: _____________________________________________________________________

Current Age: ___________   Gender: _____Female     _____Male

Person witnessing allergic reaction: _______________________________________________

Time of allergic reaction: ________________________________________________________

Was the student breathing upon your arrival?      _____ yes         _____ no

Were there signs of circulation upon your arrival?     _____ yes       _____ no

**Medication Given:**

Benadryl   _____ yes   _____ no   If yes, please list time given: __________

Epi-Pen #1   _____ yes   _____ no   If yes, please list time given: __________

Epi-Pen #2   _____ yes   _____ no   If yes, please list time given: __________

Call 911   _____ yes   _____ no   If yes, time called: _______   time of arrival: ______

Parent/Guardian Contacted: _________________________________ Time of arrival: ________

Condition of student upon arrival of EMS:

___________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Form is in compliance with SB27
Transported by:  ______ Parent  ______ EMS  ______ Not transported off campus

Outcomes:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

School Nurse Notified: ______ yes ______ no  Date/Time: _________________________
Superintendent Notified: ______ yes ______ no  Date/Time: _________________________

1.) Student had a known allergy
2.) Student had Individual Health Care Plan
3.) Student had Emergency Action Plan
4.) Student had medications and Parent Authorization
5.) Medications are readily accessible
6.) Trained staff responded appropriately (quickly activated plan, administered medications correctly, notified appropriately)
7.) Student was closely monitored (VS, respiratory effort, color)
8.) EMS arrived quickly (5-7 minutes)
9.) Student was stable upon arrival
10.) Student was transported by EMS and parents were notified
11.) Student was transported by parents

12.) Were there any barriers to delivery of care that resulted in a delay of care?
______________________________________________________________________________
______________________________________________________________________________

13.) Discuss and list challenges with clinical manager and areas to improve.
______________________________________________________________________________
______________________________________________________________________________

14.) Educate appropriate staff about any changes or updates to the protocol for responding to and/or treating students.

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