

**INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH
FOOD & 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 *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.

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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.
- Consider giving additional medications following epinephrine:
 - Antihistamine
 - Inhaler (bronchodilator) if wheezing
- 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.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert Emergency Contacts.
- 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

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person, **ALERT** Emergency Contacts.
- 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