Parent/Student

School Health Handbook

2018-2019

TCISD Parent/Student Handbook of School Health Information

2018-2019

Parent / Student Handbook of School Health Information Acknowledgment Form

My child and I have received a copy of the **Parent / Student Handbook of School Health Information** for 2018-2019. I understand that the handbook contains information that my child and I may need during the school year.

Printed name of Student: _____

Print name of Parent: _____

Signature of Parent: _____

Emergency telephone number: _____

Date: _____

School: _____

Grade Level: _____

Please sign this page and complete the requested information. Remove the page from the handbook and return it to your child's school within 10 school days of enrollment. Thank you.

Parent/Student Handbook of
School Health Information
Acknowledgement Form

My child and I have been offered the option to receive a paper copy or to electronically access at www.tcisd.org the Texas City ISD Parent/Student Handbook of School Health Information for 2017-2018.
I have chosen to:

- ☐ Accept responsibility to pick up a paper copy of the TCISD Parent/Student Handbook of School Health Information from the school office.
- ☐ Accept responsibility for accessing the Student Handbook by visiting the Web address listed above.

I understand that the handbook contains information that my child and I may need during the school year

Printed name of student: _____

Printed name of parent: _____

Signature of parent: _____

Emergency Phone Number: _____

School: _____

Grade Level: _____

Date: _____

Please sign and date this page and return it to your campus office staff with in the first week of the 2018-2019 school year.

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SECTION I

Directory of School Clinics

CALVIN VINCENT PRE-KINDERGARTEN / HEADSTART

Nurse	Bailey Martin	(409) 942-2452

HEIGHTS ELEMENTARY

Nurse	Melissa Peck	(409) 916-0507

KOHFELDT ELEMENTARY

Nurse	Melissa Guevara	(409) 916-0448

NORTHSIDE ELEMENTARY

Nurse	Shelly Cox	(409) 916-0305

ROOSEVELT-WILSON ELEMENTARY

Nurse	Kathy Montalbano	(409) 916-0205

LEVI FRY INTERMEDIATE

Nurse	Lisa Kelly-McDonald	(409) 916-0663

BLOCKER MIDDLE SCHOOL

Nurse	Melissa McCoy	(409) 916-0713

TEXAS CITY HIGH SCHOOL

Nurse	Lisa Mejia	(409) 916-0840

LA MARQUE HIGH SCHOOL

Nurse	Gia Robinson	(409) 938-4261

LA MARQUE MIDDLE SCHOOL

Nurse	Danielle Robinson	(409) 938-4286

LA MARQUE ELEMENTARY

Nurse	Stacy Smith	(409) 908-5100

LA MARQUE PRIMARY

Nurse	Gina Mata	(409) 935-3020

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SECTION II

Immunizations

TEXAS Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

Dear Parents/Guardians of Students in Texas Schools, Kindergarten through 12th Grade:

State law requires students in Texas schools to be immunized against certain vaccine-preventable diseases. This letter is to inform you of where you can obtain information about which vaccines your child needs to attend school and also to remind you to get your child's vaccinations early— before the busy back-to-school season. Getting your child vaccinated not only protects your child's health, but also that of the community.

To determine the specific vaccines that are required for your child's grade level, please refer to the Texas Minimum State Vaccine Requirements for Students in Grades K-12. This document is available on the Department of State Health Services (DSHS) Immunization Unit website at www.ImmunizeTexas.com. If you are unsure of where your child can receive vaccines, contact your health-care provider or local health department. **Without the proper documentation of required vaccinations or a valid medical or conscientious exemption, students will not be allowed to attend school.**

Should you have any questions about the required vaccines, please consult your healthcare provider.

You can also visit the DSHS Immunization Unit website at www.ImmunizeTexas.com or call the DSHS Immunization Unit customer service number at (800) 252-9152. Thank you for keeping your child immunized and free from vaccine-preventable diseases. We wish you a rewarding and productive 2018-2019 school year!

Sincerely,

Nancy Ejuma

Immunization Unit Director

Immunizations

A student must be fully immunized against certain diseases or must present a certificate or statement that, for medical reasons or reasons of conscience, including a religious belief, the student will not be immunized.

For exemptions based on reasons of conscience, only official forms issued by the Department of State Health Services, Immunization Division, can be honored by the District.

The immunizations required are: diphtheria, rubeola (measles), rubella, mumps, tetanus, haemophilus influenzae type B, meningococcal, poliomyelitis, hepatitis A, hepatitis B, and varicella (chicken pox).

The school nurse can provide information on age-appropriate doses or on an acceptable physician-validated history of illness required by the Department of State Health Services. Proof of immunization may be personal records from a licensed physician or public health clinic with a signature or rubber-stamp validation.

If a student should not be immunized for medical reasons, the student or parent must present a certificate signed by a U.S. licensed physician stating that, in the doctor's opinion, the immunization required poses a significant risk to the health and well-being of the student or any member of the student's family or household. This certificate must be renewed yearly unless the physician specifies a life-long condition.

[For further information, see policy FFAB and the Department of State Health Services Web site: http://www.dshs.texas.gov/immunize/school/default.shtm]

2018 - 2019 Texas Minimum State Vaccine Requirements for Students Grades K - 12

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This document is not intended as a substitute for the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Texas Education Code, Chapter 38.

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a child-care facility or public or private elementary or secondary school in Texas.

Vaccine Required (Attention to notes and footnotes)	Minimum Number of Doses Required by Grade Level													Notes
	Grades K - 6th							Grade 7th	Grades 8th - 12th					
	K	1	2	3	4	5	6	7	8	9	10	11	12	
Diphtheria/Tetanus/Pertussis[1] (DTaP/DTP/DT/Td/Tdap)	5 doses or 4 doses							3 dose primary series and 1 Tdap / Td booster *within the last 5 years*	3 dose primary series and 1 Tdap / Td booster *within the last 10 years*					**For K – 6th grade:** 5 doses of diphtheria-tetanus-pertussis vaccine; 1 dose must have been received on or after the 4th birthday. However, 4 doses meet the requirement if the 4th dose was received on or after the 4th birthday. For students aged 7 years and older, 3 doses meet the requirement if 1 dose was received on or after the 4th birthday. **For 7th grade:** 1 dose of Tdap is required if at least 5 years have passed since the last dose of tetanus-containing vaccine. **For 8th – 12th grade:** 1 dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine. Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.
Polio[1]	4 doses or 3 doses													**For K – 12th grade:** 4 doses of polio; 1 dose must be received on or after the 4th birthday. However, 3 doses meet the requirement if the 3rd dose was received on or after the 4th birthday.
Measles, Mumps, and Rubella[1, 2] (MMR)	2 doses													**For K – 12th grade:** 2 doses are required, with the 1st dose received on or after the 1st birthday. Students vaccinated prior to 2009 with 2 doses of measles and one dose each of rubella and mumps satisfy this requirement.
Hepatitis B[2]	3 doses													For students aged 11 – 15 years, 2 doses meet the requirement if adult hepatitis B vaccine (Recombivax®) was received. Dosage (10 mcg /1.0 mL) and type of vaccine (Recombivax®) must be clearly documented. If Recombivax® was not the vaccine received, a 3-dose series is required.
Varicella[1, 2, 3]	2 doses													The 1st dose of varicella must be received on or after the 1st birthday. **For K – 12th grade:** 2 doses are required.
Meningococcal[1] (MCV4)								1 dose						For 7th – 12th grade, 1 dose of quadrivalent meningococcal conjugate vaccine is required on or after the student's 11th birthday. **Note:** If a student received the vaccine at 10 years of age, this will satisfy the requirement.
Hepatitis A[1, 2]	2 doses													The 1st dose of hepatitis A must be received on or after the 1st birthday. **For K – 9th grade:** 2 doses are required.

Exemptions

The law allows (a) physicians to write a statement stating that the vaccine(s) required would be medically harmful or injurious to the health and well-being of the child, and (b) parents/guardians to choose an exemption from immunizations requirements for reasons of conscience, including a religious belief. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem).

For children needing medical exemptions, a written statement by the physician should be submitted to the school.

Instructions for the affidavit to be signed by parents/guardians choosing the exemption for reasons of conscience, including a religious belief can be found at www.ImmunizeTexas.com.

Schools should maintain an up-to-date list of students with exemptions, so they can be excluded from attending school if an outbreak occurs.

Provisional Enrollment

All immunizations should be completed by the first date of attendance. The law requires that students be fully vaccinated against the specified diseases. A student may be enrolled provisionally if the student has an immunization record that indicates the student has received at least one dose of each specified age-appropriate vaccine required by this rule. To remain enrolled, the student must complete the required subsequent doses in each vaccine series on schedule and as rapidly as is medically feasible and provide acceptable evidence of vaccination to the school. A school nurse or school administrator shall review the immunization status of a provisionally enrolled student every 30 days to ensure continued compliance in completing the required doses of vaccination. If, at the end of the 30-day period, a student has not received a subsequent dose of vaccine, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered.

Additional guidelines for provisional enrollment of students transferring from one Texas public or private school to another, students who are dependents of active duty military, and students who are homeless can be found in the TAC, Title 25 Health Services, Sections 97.66 and 97.69.

Documentation

Since many types of personal immunization records are in use, any document will be acceptable provided a physician or public health personnel have validated it. The month, day, and year that the vaccination was received must be recorded on all school immunization records created or updated after September 1, 1991.

For additional information or clarification, please contact the Texas Department of State Health Services, Immunization Branch at (800) 252-9152, visit the website at www.ImmunizeTexas.com, or contact your child's school nurse.

TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats. A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Not Sure
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: Has your child been around anyone with any of these symptoms or problems? or Has your child had any of these symptoms or problems? or Has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes _____ (if yes, specify date _____) No _____

Has your child ever had a positive TB skin test? Yes _____ (if yes, specify date _____) No_ ___

or school/healthcare provider use only

****

PPD administered Yes _____ No _____ If yes;
Date administered _____ Date read _____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
Signature Printed Name

Provider phone number_____
City _____ County _____

If positive, referral to healthcare provider Yes _____ No _____
If yes, name of provider _____

SECTION III

Student Illnesses

Texas City school nurses are proud to be a part of your child's education. Success in school is directly related to the good health and emotional well-being of each student. *Responsibility for the care of children lies primarily with parents*. The nurses in TCISD are here to assist and support parent's efforts to maintain good health in their children. School nurses do not diagnose. School nurses assess and make recommendations based on that assessment. For the protection of all students, the following health rules have been set up and will be followed at all times. A child cannot remain in school with:

1) Fever of 100 degrees or over a student must be FREE FROM FEVER WITHOUT MEDICATION for 24 hours before returning to school
2) Rash or weeping sores
3) Vomiting – student should be free from vomiting for 24 hours before returning to school
4) Diarrhea (Nurses do not have access to facilities to wash soiled clothing. Soiled clothing will be sent home with the student.)
5) Red, discharging eyes, or
6) ANY ILLNESS MAKING HIM/HER FEEL TOO BADLY TO PARTICIPATE

A student having any of the above symptoms BEFORE SCHOOL SHOULD STAY AT HOME for observation and care. There are limited facilities for putting students to bed. This option will be used only until arrangements can be made for the student to go home. A student will not be sent home to be left alone without special arrangements and written permission from the parent.
Students who have been absent from school because of a communicable disease or illness diagnosed as strep throat, scarlet fever, or skin disease (Staph/MRSA skin infection, ringworm, impetigo) or pink eye are required to bring a doctor's st atement authorizing return to school . Due to an illness or injury, any student who misses three consecutive days of school must return with a note from the Doctor authorizing the return to school. The school nurse is not in a position to diagnose or treat illnesses. For question about diagnosis or treatment, a medical doctor should be consulted.

The wheelchair in the nurse's clinic is ONLY for emergencies. If a student needs a wheelchair or crutches during school hours, he/she must provide their own , as well as medical documentation from a physician that the use of the equipment is medically necessary on campus during the school day.

Emergency First Aid Care

Any treatment given at school is limited to first aid. When a pupil becomes ill or is injured at school, parents are notified. If they cannot be reached and the situation requires medical attention beyond our resources, it may be necessary to send the student to the hospital emergency service for needed care until the parents can be reached. Parents are responsible for emergency care costs.
Parents should supply the school nurse with information concerning current special health problems that are under the care of a physician.

The nurse cannot give any medications while waiting for you to pick up your child..

Contagious Diseases

The following table lists the most common contagious diseases and infestations, the incubation period of each, and the requirements for re-admission to school.

Common Contagious Diseases	Incubation Period	Requirements for Re-admission to School
Chicken Pox	2-3 weeks	Exclude for 7 days after eruption and until lesions are dry. Temperature must be normal.
Impetigo	N/A	Exclude from school until healed or until noninfectious according to a physician's written statement.
Infectious Hepatitis	15-50 days Notify school as soon as physician confirms diagnosis	Exclude until no fever and no jaundice, or until noninfectious according to a physician's written statement.
Measles	10 days to fever or 14 days to rash	Exclude when symptoms first develop and for five days after the appearance of rash.
Mumps	12-26 days	Exclude until all swelling subsides.
Pink Eye	24-72 hours	Exclude until recovered or noninfectious according to a physician's written statement.
Ringworm of the Body	4-10 days	May attend school provided child is under treatment of a physician. Affected areas must be covered at all times.
Ringworm of the Scalp	10-21 days	Exclude until after treatment has begun. Child must be under treatment of a physician. May return with physician's written statement.
Streptococcal Infection	1-3 days	Exclude until released by a physician or at least 7 days.
Head Lice	N/A	Exclude until visual inspection shows that no nits (egg cases) are within a ¼ inch of the scalp and no live lice are found.
Scabies	N/A	Exclude until physician's written statement certifies that the child has been properly treated and cleared to return to school.
Fever	N/A	Children must be excluded from school if they have a temperature >100.0 degrees Fahrenheit. Child must be free of fever without medication for 24 hrs before they can return to school.

Head Lice/Treatment

TCISD Protocol for Lice (Pediculosis):

Texas City ISD School Nurses do not routinely screen for head lice. If there is a suspected case, the nurse will perform a head check on the student and follow up with a phone call to the parent or guardian if live lice are found.

We encourage you to check your child often, especially during cold weather. Remind your child not to share hats or grooming items with other students.

Texas City ISD follows Texas Department of State Health Services guidelines when dealing with lice. For more information, contact your student's school clinic.

Texas City ISD Policy:

- According to Texas City ISD policy, students must be sent home from school if live lice are found in their hair.
- Students will not be sent home if only nits are found.
- Texas City ISD policy also states students may return to school after one medicated shampoo or lotion treatment has been given.
- When returning to school a head check by the nurse is required by the school district.

Treatment:

- Treatment must be with a lice shampoo or cream rinse approved by the FDA.
- Combing and picking out of nits is necessary to remove the nits.
- A second treatment of lice shampoo or cream rinse 7-10 days after the first treatment is needed to kill remaining or newly hatched lice.

Management:

- If treated and cleared by the campus nurse, students may return to school the same day they were sent home.
- Mass screenings are not recommended or required.
- Families of students in the classroom will not be notified if only one case is found.
- If multiple cases are found, then the classroom parents will be notified.
- If multiple cases are found in one classroom, the school custodian will be notified so a thorough cleaning can be done.

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SECTION IV

Use of Repellant and Sunscreen at School

TEXAS CITY ISD PROCEDURES FOR INSECT REPELLANT USE DURING SCHOOL HOURS

- Concerned parents are strongly encouraged to use a repellant on their child before they leave for school, especially younger children who may have difficulty applying the repellant safely.
- No repellant sprays or lotions will be provided by or applied by school personnel during the school day.
- Parents who are concerned about mosquito exposure during the school day may send a lotion, wipe-on or wristband type of repellant for use by their child. (Sprays pose the risk of accidental exposure and will not be allowed.)
- Parents should instruct their child in the proper use and application of an acceptable repellant (wipes or lotion), since it will be retained in the child's possession (backpack, etc.) for use when going outside for activities or practices.
- Students with physical limitations that make it impossible to self-apply a repellant will need to bring a parent note from home along with the repellant.

SAFE USE OF INSECT REPELLANTS

- Always follow the label recommendations.
- Apply to exposed skin and clothing. Do not apply under clothing or over cuts, wounds, or irritated skin.
- Look for repellants that have DEET (N, N-diethyl-m-toluamide) for the best protection against mosquitoes.
- After returning indoors, wash treated skin with soap and water.
- Apply to face by putting repellant on hands and rubbing it carefully over the face.

USE OF SUNSCREEN PRODUCTS AT SCHOOL – SENATE BILL 265

- A student may possess and use a topical sunscreen product while on school property and at a school related event or activity to avoid overexposure to the sun.
- No aerosol products are permitted and the product must be approved by the FDA (Federal Drug Administration) for over the counter use.
- If it is necessary for the campus nurse or a campus employee to assist a student due to special needs, written permission from the parent will be required.

Medication at School

District employees will not give a student prescription medication, nonprescription medication, herbal substances, anabolic steroids, or dietary supplements, with the following exceptions:

Only authorized employees, in accordance with policies at FFAC, may administer:

- Prescription medication, in the original, properly labeled container, provided by the parent, along with a District form that has been signed by the student's physician and parent.
- Prescription medication from a properly labeled unit dosage container filled by a registered nurse or another qualified District employee from the original, properly labeled container (i.e. field trips).
- Nonprescription medication, in the original, properly labeled container, provided by the parent, along with a parent's written request and with a physician's written approval.
- Herbal or dietary supplements provided by the parent only if required by the student's individualized education program (IEP) or Section 504 plan for a student with disabilities.

In certain emergency situations, the District will maintain and administer to a student nonprescription medication, but only in accordance with:

- Protocols established by the District's medical advisor who must be licensed to practice medicine in the state of Texas; and
- When the parent has previously provided written consent to emergency treatment on the back of the District's emergency contact cards supplied to parents by the District.
- A student with asthma or severe allergic reaction (anaphylaxis) may be permitted to possess and use prescribed asthma or anaphylaxis medication at school or school-related events only if he or she has written authorization from his or her parent and a physician or other licensed health-care provider. The student must also demonstrate to his or her physician or health-care provider and to the school nurse the ability to use the prescribed medication, including any device required to administer the medication. If the student has been prescribed asthma or anaphylaxis medication for use during the school day, the student and parents should discuss this with the school nurse or principal.

In accordance with a student's individual health plan for management of diabetes, a student with diabetes will be permitted to possess and use monitoring and treatment supplies and equipment while at school or at a school-related activity. See the school nurse or principal for information. [See policy FFAF (LEGAL).]

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

In-School Administration of Medication

Parent Request and Doctor Orders

Per Texas City Independent School District policy, school nurses are not permitted to give medication of any kind, prescription and non-prescription, unless a physician requests in writing that there is a need for such medication.

Date _____

Name of Student _____ Date of Birth _____

Name of Medication _____

Diagnosis _____

Route: _____ Dosage: _____

How often or at what time: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

_____
Physician Signature

_____
Physician's Phone Number

- The doctor's statement must be accompanied by written permission of at least one parent.
- I agree to be responsible for maintaining an adequate supply of prescription medication at the school to meet your child's needs.
- I give permission for the medication(s) to be given to my child by designated personnel as delegated by the school nurse.

_____ Work Phone: _____
Parent/Guardian Signature

Home Phone: _____ Cell Phone: _____

Texas City Independent School District
1700 Ninth Avenue North, Texas City, Texas 77590

PHYSICIAN'S MEDICATION AUTHORIZATION

T.C.I.S.D. AUTHORIZATION FOR MEDICATION TO BE TAKEN ON OVERNIGHT FIELD TRIPS

I REQUEST THAT MY CHILD BE ASSISTED IN TAKING THE MEDICATION DESCRIBED BELOW OR THAT HE/SHE SELF-ADMINISTER THE MEDICATION AUTHORIZED BY MYSELF AND MY PHYSICIAN. THE MEDICATION IS TO BE SUPPLIED BY THE PARENT AS NEEDED.

STUDENT _____ ID# _____ TEACHER _____

DATE OF BIRTH _____ DIAGNOSIS _____

MEDICATION _____ DOSE _____

ROUTE _____ TIME _____

*MEDICATION IS TAKEN AT HOME AS FOLLOWS: DOSE _____ TIME _____

SIDE EFFECTS _____ SPECIAL INSTRUCTIONS _____

_____

MEDICATION _____ DOSE _____

ROUTE _____ TIME _____

*MEDICATION IS TAKEN AT HOME AS FOLLOWS: DOSE _____ TIME _____

SIDE EFFECTS _____ SPECIAL INSTRUCTIONS _____

_____

_____ _____

PHYSICIAN SIGNATURE AND DATE PRINTED NAME

_____ _____

PHYSICIAN'S PHONE NUMBER PHYSICIAN'S FAX NUMBER

_____ _____

PARENT/GUARDIAN SIGNATURE AND DATE PARENT/GUARDIAN PRINTED NAME

SECTION V

Student Self Administration of Metered Dose Inhaler Guidelines

In accordance with policy FFAC (LEGAL), a student with asthma or severe allergic reaction (anaphylaxis) may be permitted to possess and use prescribed asthma or anaphylaxis medication at school or school-related events only if he or she has written authorization from his or her parent and a physician or other licensed health-care provider. The student must also demonstrate to his or her physician or health-care provider and to the school nurse the ability to use the prescribed medication, including any device required to administer the medication. If the student has been prescribed asthma or anaphylaxis medication for use during the school day, the student and parents should discuss this with the school nurse or principal.

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Authorization for Administration of Prescribed Inhaled Medication

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication Strength	Dose	Time	Route	Side Effects Possible
1.					
2.					
3.					

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use an inhaler.

☐ Student may self-administer the medication. (Not applicable for controlled substances.)

_____ _____
Print or Type Name of Physician/Licensed Prescriber Signature

_____ _____ _____
Clinic Address Phone Number Date

Parent/Guardian Authorization - Please initial the following:

_____I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.

_____ I release school personnel from liability in the event adverse reactions result from taking the medication(s).

_____ I will notify the school of any change in the medication(s), (e.g. medication change, dosage change, medication is discontinued, etc.)

_____ I give permission for the school nurse to communicate with my child's teachers about the student's health condition(s) and the action of the medication(s).

_____ I give permission for the school nurse to consult with my child's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ My son/daughter may self-administer his/her inhaled medication(s). (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

_____	_____	_____
Date	Parent/Guardian Signature	Relationship to Student

Note: Medication must be supplied in the original prescription bottle and the container (<u>not the box</u>) must be properly labeled with the prescription/pharmacy label with the student's name, type of medication, dosage, route and time noted.

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SECTION VI

Diabetes Management and Treatment Plan

In accordance with a student's individual health plan for management of diabetes, a student with diabetes will be permitted to possess and use monitoring and treatment supplies and equipment while at school or at a school-related activity. See the school nurse or principal for information. [See policy FFAF.]

The parent or guardian of a student who will seek care for diabetes while at school or while participating in a school activity, and the physician responsible for the student's diabetes treatment, shall develop a Diabetes Management and Treatment Plan (DMTP).

The DMTP must:

1. Identify the health-care services the student may receive at school;

2. Evaluate the student's ability to manage and level of understanding of the student's diabetes; and

3. Be signed by the parent or legal guardian and the child's physician.

The parent or guardian must submit the DMTP to the school as soon as practicable following a diagnosis of diabetes for the student. [Health and Safety Code 168.002]

The school will work in concert with families of students with diabetes and will involve parents or legal guardians in the development of the DMTP.

Guidelines for Self-Management of Diabetes Medication at School

TCISD is fully committed to supporting our diabetic students who desire to carry their supplies and self-manage their diabetes while at school and school sponsored events. It is important that parents communicate with the school nurse, teachers, and coaches at the start of the school year regarding the student's diabetes care. Your school nurse will continue to be available to assist both the diabetic student and parents as needed. Please do not hesitate to enlist the support of TCISD's professional staff.

The safety of all TCISD students is a primary concern of our district staff. For the safety of the diabetic students as well as others, the following guidelines have been developed. **Please read and sign the bottom of this form and return it to the school nurse indicating that you have read the guidelines listed below.**

- Both parent and physician's signatures are required on the *Diabetic Management and Treatment Plan (DMTP)*, and must be on file in the school nurse's office before the student will be permitted to carry diabetic supplies at school. The form must be renewed at the beginning of every school year.
- The student must supply all diabetic equipment. The school does not stock reserve supplies. Parents are strongly encouraged to provide the school nurse with a secondary supply of emergency equipment (e.g. a glucometer, lancets and glucagons) in case the student becomes ill and his/her equipment is not available.
- Students may not share their equipment with other students. Stolen or missing supplies should be immediately reported to the school nurse or campus principal (if nurse is not available).
- Students are required to carry and properly use a personal sharps disposal container, and should care for puncture sites and blood in such a way that others are not inadvertently exposed to the student's blood.
- Diabetic supplies should be kept in the student's direct possession at all times so that other students can't easily access the supplies (The exceptions would be when the equipment is in the possession of a staff member.).
- Equipment should be stored in a safe manner (i.e. so that glass insulin bottles wouldn't be bumped or broken or others would not be punctured by sharps.).
- Snacks may not be shared with peers in the classroom and should be an appropriate type of carbohydrate.
- Students are expected to test and treat symptoms in class in the least disruptive manner possible. A nearby staff member should be notified immediately if a student becomes ill or feels they may need assistance. **Please do not hesitate to ask for assistance.**

These guidelines apply to all school related activities. Because of the potential harm to self or others that could arise, infractions of these guidelines will be referred for disciplinary action.

_____ _____

Student Signature Date

_____ _____

Parent Signature Date

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Physician's Authorization for Student Self-Management of Diabetes

I have instructed _____ in the proper self-management of diabetes, including:
(Student's name)

Physician's initials:

_____ Blood glucose testing
_____ Insulin administration
_____ Emergency treatment, including the use of fast acting carbohydrates and Glucagons.

This patient has been instructed in related safety precautions including the proper disposal of sharps and blood-soiled items.

I have completed and attached a ***Diabetic Management and Treatment Plan***, which includes physician directives for:
Physician's initials:
_____Blood glucose testing
_____Urine ketone testing
_____Appropriate response to abnormal blood sugar levels
_____Diabetic medications including Insulin (if applicable at school) and Glucagon.

Please initial one of the two choices below:

_____ In my professional opinion, this student should be allowed to carry diabetic supplies, including lancets and syringes, on his/her person, as well as to self–administer and manage diabetes testing and treatment while at school or school related events.

_____ In my professional opinion this student should **NOT** be allowed to carry diabetic equipment on his/her own person while at school or school related events.

_____ _____
Physician's Signature Date

_____ _____
Printed Physician's Name Physician's Phone Number

I agree with the physician's recommendations as noted above and have informed my child.

_____ _____
Parent's Signature Date

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Diabetes Medical Treatment Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

_____

_____

Blood Glucose Monitoring

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ other _____

Usual times to check blood glucose _____

Times to do extra blood glucose checks (*check all that apply*)

☐ Before exercise

☐ After exercise

☐ When student exhibits symptoms of hyperglycemia

☐ When student exhibits symptoms of hypoglycemia

☐ Other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

_____

Type of blood glucose meter student uses: _____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____units/ _____grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood Glucose levels. ☐ Yes ☐ No

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw correct dose of insulin? ☐ Yes ☐ No

Parents are authorized to adjust the insulin dosage under the following circumstances: _____

_____

_____

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	**Needs Assistance**	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

_____

Preferred snack foods: _____

_____

Foods to avoid, if any: _____

_____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below _____mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____, Dosage _____, site for glucagon injection: _____arm, _____thigh, _____other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

_____

Supplies to be Kept at School

_____Blood glucose meter, blood glucose test strips, batteries for meter

_____Lancet device, lancets, gloves, etc.

_____Urine ketone strips

_____Insulin pump and supplies

_____Insulin pen, pen needles, insulin cartridges

_____Fast-acting source of glucose

_____Carbohydrate containing snack

_____Glucagon emergency kit

This Diabetes Medical Treatment Plan has been approved by

_____ _____

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by_____'s Diabetes Medical Treatment Plan. I also consent to the release of the information contained in this Diabetes Medical Treatment Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

_____ _____

Student's Parent/Guardian Date

(For School Use Only)

Plan has been reviewed by the following campus representatives:

Relationship to Student	Printed Name	Signature	Date
School Nurse			
School Administrator			
School Administrator			
Unlicensed Diabetes Care Assistant			
Classroom Teacher			

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Authorization for Administration of Diabetes Management and Care Services by Unlicensed Diabetes Care Assistant

Information to Parents:

The health and safety of each student is always of paramount importance to every TCISD employee. The District is committed to providing a high level of care to meet any special medical needs students may exhibit.

To help carry out that commitment, TCISD ensures that a Registered Nurse is assigned to each campus. The 79th Texas Legislature, through House Bill 984, amended the Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school.

The school, in conjunction with the parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school.

Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services.

Such services include the administration of insulin, or in an emergency, Glucagon. TCISD has trained staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

Please initial the appropriate box below to indicate your preference:

❑ YES Agreement for Services: I authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school. I understand that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

❑ NO I DO NOT authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school.

Please initial below if your child will manage his/her diabetes independently while at school:

❑ YES My child can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

Please initial below if you would like your child's classmates to be informed of your child's diabetes:

❑ YES I request that my child's classmates be informed that my child has diabetes, and given age-appropriate instruction regarding diabetes care, so that they understand the importance of symptoms and the types of intervention that may occur in the classroom.

Student's Name *(Please Print)*	School
Signature of Parent/Guardian	Date Signed

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Diabetic Health Care Plan

To be Completed by child's School Nurse

Student's Name: _____ Date:_____ School:

Grade_____ Date of Birth: _____ Student

ID #: _____ Homeroom Teacher: _____

Comments: _____

_____

_____

Health Action Plan

Daily Snacks

- Snack times: _____
- Does the student carry snacks with him/her? _____
- Location of snacks at school: _____

Blood Sugar Test

- Time: _____Location: _____

Insulin injection

- Does the student have insulin injections at school? _____
- Time: _____Location: _____
- Does the student carry his/her own supplies? _____
- Location at school? _____

Other Plan Items

_____

_____

(Diabetic Health Care Plan, p. 2)

Daily Time Schedule: (include snack times, recess, lunch, insulin injection times, etc.)_____

_____

Additional Information

Concurrent illness or disability? _____

Social/Emotional Factors: _____

_____

Concurrent Medications? _____ Allergies?

Dietary Concerns/restrictions? _____ **Contact Information**

Parent/Guardian's Name(s): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Address:

Emergency Contact: _____ Phone: _____ Primary Care Physician: _____ Phone: _____ Specialty MD: _____ Phone: _____

Contingency Plan when unable to contact parent in emergency: (i.e. order to call above numbers) _____

_____

_____

_____

Disaster kit at school? _____If so, where is it located? _____

Print Name	Signature	Relationship to Student	Date

****Note: Parent MUST sign this form.

_____

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Individualized Health Plan (Off-Campus Activity Sheet)

I. Identifying Information

- Student's Name _____
- School _____
- Nurse _____
- Date of Birth _____
- Age _____
- Grade _____
- Classroom Teacher _____

- Mother's Name _____
- Address _____
- Home Phone # _____
- Work Phone # _____
- Cell Phone # _____

- Father's Name _____
- Address _____
- Home Phone # _____
- Work Phone # _____
- Cell Phone # _____

- Child's Physician _____
- Physician's Phone # _____
- Physician's Pager # _____

II. Medical Information

- Condition: Type I Diabetes
- Complications:

1. **Hypoglycemia** (low blood glucose)

    - Mild/moderate symptoms: shaky, sweaty, hungry, sleepy, dizzy, disoriented, and/or lethargic
    - Severe symptoms: inability to swallow, seizure or convulsions, and/or unconsciousness

2. **Hyperglycemia** (high blood glucose)
    - Mild/moderate symptoms: thirst, frequent urination, nausea, blurry vision, and/or fatigue
    - Severe symptoms: fruity breath odor, nausea, vomiting, stomach pain, and/or deep breathing and sleepiness

- Recommended Actions:
    - Contact parent(s)
    - Contact school nurse
    - Contact emergency personnel if symptoms are severe

SECTION VII

Severe Allergies and Treatment Plan

The following procedures are in accordance with the state-developed *Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis.*

REQUEST FOR FOOD ALLERGY INFORMATION

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 District in order to enable the District to take necessary precautions for your child's safety.

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

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's allergic reaction to the food.

Food:	**Nature of allergic reaction to the food:**

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Educational Rights and Privacy Act and District policy. [See FL]

Student name: _____ Date of birth: _____

Grade: _____

Parent/Guardian name: _____

Work phone: _____ Home phone: _____

Parent/Guardian Signature: _____ Date: _____

Date form was received by the school: _____

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Dear Parent:

You have disclosed that your child has a severe food allergy. The District requires additional information in order to take necessary precautions for your child's safety and to authorize treatment of your child in the event of an allergic reaction at school or at a school-related activity. Attached to this letter are the following forms:

1. Request for the Administration of Medication at School
2. Authorization to Secure Emergency Medical Treatment of a Student
3. Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication
4. Statement Regarding Meal Substitutions or Modifications and signed by your child's Doctor.
5. Food Allergy & Anaphylaxis Emergency Care Plan (FARE)

Please have your physician or other licensed health-care provider complete these forms and return them to the office as soon as possible.

Sincerely,

_____

Campus Nurse

Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

STATEMENT REGARDING MEAL SUBSTITUTIONS OR MODIFICATIONS

Note: Information regarding accommodating children with special dietary needs can be found on the Texas Department of Agriculture Web site at http://www.squaremeals.org/Portals/8/files/ARM/Section%2013-Accommodating%20Children%20with%20Special%20Dietary%20Needs.pdf.

The United States Department of Agriculture regulations require substitutions or modifications in school meals for children whose disabilities restrict their diets. If a physician or other licensed health-care provider determines that a child's food allergies may result in severe, life-threatening (anaphylactic) reactions, then the child's condition will meet the definition of a disability, and the prescribed substitutions must be made by the District. In order to do so, the school nutrition program must receive a signed statement by the physician or other licensed health-care provider containing the following information:

The child's food allergy that constitutes a disability: _____

_____

An explanation of why the disability restricts the child's diet: _____

_____

The major life activity affected by the disability: _____

_____

The food(s) to be omitted from the child's diet: _____

_____

The food or choice of foods that must be substituted: _____

_____

Physician Information:

Name: _____ Address:

Phone Number: _____

Physician Signature: _____ Date: _____

For Office Use Only:

Date form was received by the school: _____

Student name: _____ Date of birth: _____

Grade: _____

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

INDIVIDUALIZED ALLERGY HEALTH-CARE PLAN

Note: If applicable, a student's individualized health-care plan must be coordinated with his or her Section 504 plan. [See FB for information regarding the application of Section 504 of the Rehabilitation Act to students who qualify for individualized health-care plans.]

Student name: _____ Date of birth: _____

Grade: _____

Primary health concerns/diagnoses: _____

_____

_____

Secondary health concerns/diagnoses: _____

_____

_____

Treating physician(s) information:

Name: _____ Address:

Phone Number: _____

Name: _____

Address: _____

Phone Number: _____

Name: _____ Address:

Phone Number: _____

Current medications* [see FFAC]:

_____

_____

_____

*Attach the Request for the Administration of Medication at School and/or the Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication, found at FFAC(EXHIBIT), as necessary.

Medical equipment:

_____

_____

_____

Diagnosis:	Assessment:	Goal:	Implementation / Intervention**:	Anticipated outcome:	Evaluation:

**Attach an emergency health plan related to student's diagnosis, if necessary.

Effective date: _____

Parent's signature: _____ Date: _____

Nurse's signature: _____ Date: _____

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Authorization for Administration of Prescribed Allergy Medication

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication Strength	Dose	Time	Route	Side Effects Possible
1.					
2.					
3.					

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use medication.

☐ Student may self-administer the medication. (Not applicable for controlled substances.)

_____ _____
Print or Type Name of Physician/Licensed Prescriber Signature

_____ _____ _____
Clinic Address Phone Number Date

Parent/Guardian Authorization - Please initial the following:

_____I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.

_____ I release school personnel from liability in the event adverse reactions result from taking the medication(s).

_____ I will notify the school of any change in the medication(s), (e.g. medication change, dosage change, medication is discontinued, etc.)

_____ I give permission for the school nurse to communicate with my child's teachers about the student's health condition(s) and the action of the medication(s).

_____ I give permission for the school nurse to consult with my child's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ My son/daughter may self-administer his/her allergy medication(s). (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

_____	_____	_____
Date	Parent/Guardian Signature	Relationship to Student

Note: Medication must be supplied in the original prescription bottle and the container (<u>not the box</u>) must be properly labeled with the prescription/pharmacy label with the student's name, type of medication, dosage, route and time noted.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 (e.g., inhaler-bronchodilator if asthmatic): _____

_____

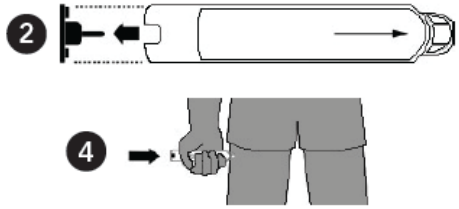
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

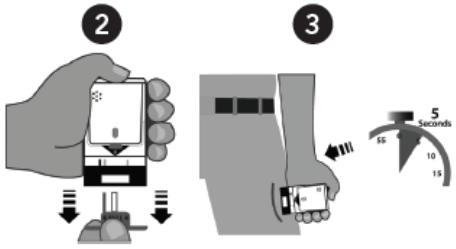
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

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.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

Texas City Independent School District
1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

ANAPHYLAXIS INCIDENT REPORT FORM

Student name: _____ Date of birth: _____

Campus: _____ Grade: _____

Date of incident: _____

If known, the location and source of the allergen exposure:

_____

Emergency action taken (attach additional pages if more space is needed):

_____

_____

_____

_____

Were emergency services contacted?

☐ Yes ☐ No

Was an epinephrine auto-injector used?

☐ Yes ☐ No

If yes, who administered the epinephrine?

☐ Student (self-administration)

☐ Staff (provide name and position title): _____

☐ Other: _____

Are any changes to procedures recommended?

_____

_____

_____

Signature: _____ Date: _____

Received By: _____ Date: _____

SECTION VIII

Medical Excuses for Physical Education/Recess

A written excuse is required if a child is not to participate in physical education. If the child is to be excused more than three (3) consecutive days, a physician's statement is required. A child who has been excused from physical education will also be excused from recess. Examples for exclusion from physical education/ recess by a physician: sutures, fractures (casts), or post-surgery. In order to return to physical education/recess, a student must have a written release from their physician (not a parent).

All physicians' notes must be turned in to the nurse's office.

SECTION IX

Policies related to student welfare and health services can be accessed at www.tcisd.org:

Relevant Texas City ISD Policies

FFAE
FFAD
FFAF
FFA
FFB