Weslaco Independent School District

Procedure for Self-Administration of [redacted] Anaphylaxis Medication in the Schools

In accordance with FFAC (Legal), a student with asthma or anaphylaxis may possess and self-administer prescription asthma or anaphylaxis medication while on school property or at a school-based event or activity as long as certain criteria are met.

1. The prescription medication must be brought in the original, properly labeled container;
2. A written statement from the physician or licensed health care provider that states that the student has asthma or anaphylaxis and may carry and self-administer the prescription medication in school must be submitted to the school nurse annually;
3. The parent /guardian must sign a copy of the WISD Parent Consent for a Minor's Self-Administration of Prescription Asthma or Anaphylaxis Medication in School form giving authorization to allow the student to carry and self-administer the prescription medication in school;
4. The school nurse will review the information submitted with the student, discuss the steps for administering the medication and check the skills of the student. The student must demonstrate to the school nurse the skill level necessary to self-administer the medication including the use of any device required to administer the medication. If these skills are not shown, the nurse can deny the student the ability to self administer, and inform the parent and physician;
5. **The student is instructed and the parent is told that if it is necessary to self – administer the medicine for reasons other than routine(e.g. before PE) , the student will proceed to the nurse's office, or have someone call the nurse;**
6. The nurse will then assess the student's condition. If the condition does not improve, the parent is notified or if the student is in distress, 911 will be called.

August 2006

Weslaco Independent School District
Allergic Reaction /Anaphylaxis Emergency Plan

Date:_____
(All authorizations expire at end of current school year)

Student:_____ **DOB**:_____

Severe allergic or anaphylactic reaction to:
_____Insect bites or stings(list)_____
_____Foods(list)_____
_____Other_____
Asthmatic: Yes*____ No____ (* At higher risk for severe reaction)

Physician's Orders:(**All** medications are provided by parent/guardian)
Medication:_____Dosage_____
Medication:_____Dosage:_____
Time/Frequency:_____
Termination Date:_____
Special Instructions:_____
_____

Treatment of Symptoms:	Epinephrine	Antihistamine
If a food allergen has been ingested, but ***no symptoms***:		
Mouth - c/o itching, tingling, swelling of lips, tongue, mouth:		
Skin - Hives, itchy rash, swelling of face or extremities:		
Abdominal - Nausea, cramps, vomiting, diarrhea:		
Throat† - Tightening of throat, hoarseness, hacking cough:		
Lungs† - Shortness of breath, repetitive coughing, wheezing:		
Heart† - Weak pulse, ↓ blood pressure, fainting, pale color		
Other†:		
If reaction is progressing (several area above are affected), give:		

† Potentially life-threatening. The severity of symptoms can quickly progress.

Physican's Name:_____
Phone Number: _____Fax:_____

☐ This patient has been informed about the above named medication and has been instructed in correct administration. It is my professional opinion, that he/she should be allowed to carry and self-administer the medication.

☐ It is my professional opinion,that this patient should not carry or self-administer the above named medication.

☐ Patient wears Medic Alert ID (bracelet or necklace).

Physican's Name:_____
Phone #: _____Fax #:_____

Physician's Signature_____

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