KNOX COUNTY SCHOOLS
ANDREW JOHNSON BUILDING

HEALTH SERVICES

SELF-POSSESSION OF SELF-ADMINISTERED ANAPHYLAXIS MEDICATION

Tennessee Code Annotated, Section 49-5-415(F) has been amended to allow a student with anaphylaxis to be entitled to possess and self-administer prescription anaphylaxis medication while on school property or at a school-related event or activity if:

- The prescription anaphylaxis medication has been prescribed for that student as indicated by the prescription label on the medication.
- The self-administration is done in compliance with the prescription or written instructions from the student's health care provider or other licensed health care provider.
- A parent of the student provides to the school written authorization for the student to self-administer prescription anaphylaxis medication while on school property or at a school related event.
- A written statement from the student's licensed health care provider that states:

  – The student has anaphylaxis and is capable of self-administering the prescribed anaphylaxis medication.
  NOTE: Authorization of self possession indicates student has been properly trained.
  – ~~The name and purpose of the medication~~
  – The prescribed dosage for the medication
  – The times at which or circumstances under which the medication may be administered
  – The period of time(s) for which the medication is prescribed

The written statement must be kept on file at your child's school.

The student's parent or guardian must sign a statement acknowledging that the school district and its employees shall incur no liability for an injury arising from the student's self-administering of prescription anaphylaxis medication while on school property or at a school related event or activity, except in cases of wanton or willful misconduct.

If a student uses such medication in a manner other than prescribed, such student may be subject to disciplinary action under the school codes.

Student Name _____ DOB _____

TCA 49-5-415(F) mandates competency of student self-administration of epinephrine evaluation by school nurse twice annually.

Nurse Signature _____ Date _____ Nurse Signature _____ Date _____

I, the parent/guardian of the above named student, acknowledge that the school and its employees and agents shall incur no liability as a result of any injury sustained by the student or any other person from possession or self-administration of the anaphylaxis medication.

My child has received the appropriate training and agrees to follow the guidelines for administration and carrying on person a prescribed anaphylaxis medication.

_____ _____

Parent /Guardian Signature Date

NOTE: Parents may be provided a copy of this statement.

AD–H–494 (7/13)

KNOX COUNTY SCHOOLS
HEALTH SERVICES

ALLERGY/ANAPHYLAXIS ACTION PLAN

(To be completed by a Licensed Health Care Provider)

Student Name_____ D.O.B._____ Diagnosis/Disability_____

School_____

History of Asthma NO / YES (Higher risk for severe reaction)

ALLERGY: (CHECK APPROPRIATE)

__ Foods (list): _____
__ Medication (list): _____
__ Latex: anaphylaxis / dermatitis (circle)
__ Stinging Insects (list): _____ ** KEEP EPI-PEN WITH STUDENT WHEN OUTSIDE
__ Environmental (list): _____

RECOGNITION AND TREATMENT

If food ingested or contact w/allergen occurs: Give Checked Medication

		Epi-Pen	Antihistamine
No symptoms	*Observe / give checked medication (circle)		
MOUTH	Itching, tingling, or swelling of lip, tongue, mouth		
SKIN	Hives, itchy rash, swelling of face or extremities		
GUT	Nausea, cramps, vomiting, diarrhea		
THROAT	Tightening of throat, hoarseness, hacking cough		
RESP	Shortness of breath, coughing, wheezing		
HEART	Thready pulse, low BP, fainting, pale, cyanosis		
NEURO	Disorientation, dizziness, loss of consciousness		

DOSAGE:
Epinephrine _____ MG

Antihistamine_____ MG

__ This student has received instruction in the proper use of the EPI-PEN and may carry.
__ This student should not carry the EPI-PEN in the school setting.

**DIETARY STATEMENT (Food allergy only)
For school nutrition to provide substitutes of any kind, this form must contain foods to be omitted *and* substituted.

Foods to be Omitted (required)	Substitution Foods (required)	Additional Information (optional)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Care Provider Signature_____ Date _____
Phone_____ Fax _____

Side 2: Student_____

Parent / Guardian AUTHORIZATIONS:

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I hereby give consent for my child to be assisted in taking the medication prescribed at school.
I authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed on this form.

Yes / No- I want my child to carry the Epi-Pen and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of Epi-Pen. It is recommended that backup medication be stored with the school/school nurse.

Parent / Guardian Signature_____
Phone_____ Date_____

EMERGENCY CONTACTS

	NAME	HOME #	WORK #	CELL #
PARENT/GUARDIAN				
PARENT/GUARDIAN				
OTHER:				
OTHER:				

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated
2. Call parents/guardian to notify of reaction, treatment and student's health status
3. Treat for shock. Prepare to do CPR
4. Accompany student to ER if no parent/guardian are available.

School Nurse _____ Date_____