Allergy Action Plan

A physician should complete the information on this page.
A parent should complete page 2.

Student Information:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Parent/Guardian Information:

Parent/Guardian #1			Parent/Guardian #2		
Legal Last Name:	Legal First Name:	MI:	Legal Last Name:	Legal First Name:	MI:
Phone #1:	Phone #2:		Phone #1:	Phone #2:	

Allergy To: check appropriate box and provide specifics below

☐ Peanuts ☐ Nuts ☐ Eggs ☐ Seafood ☐ Latex ☐ Insect Stings ☐ Other

Specifics:

Medications:

EPINEPHRINE: recommended to have 2 doses on hand	**ANTIHISTAMINE**:
☐ EpiPen® Dose ____________________________ ☐ Adrenaclick™ Dose __________________________ **Epinephrine located**: ☐ Health Office ☐ Self-carry ☐ Backpack ☐ Other_____________ **Student has been instructed how to use their epinephrine:** ☐ Yes ☐ No **If able, student will give themselves epinephrine:** ☐ Yes ☐ No ☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten ☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.	☐ Benadryl (also known as Diphenhydramine) Dose: ______________________________ ☐ Other antihistamine ______________________________

Any SEVERE SYMPTOMS after suspected or known ingestion: **One or more** of the following: LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips) GUT: Vomiting, crampy pain	⇨	1. **INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 3. Begin monitoring (see box below) 4. Give additional medications.* a. Antihistamine b. Inhaler if asthma *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.
MILD SYMPTOMS ONLY: MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort	⇨	**1.** **GIVE ANTIHISTAMINE** **2.** Call parent and Licensed School Nurse **3.** If symptoms progress, (see above), USE EPINEPHRINE.

Monitoring

Stay with student; call parent and building Health Assistant &/or Lic. School Nurse. Tell 911 that epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine (if provided by parent) can be given 5 minutes or more after the first dose ***if*** a medical doctor has prescribed it, and ***if*** symptoms persist or recur.
For a severe reaction, consider keeping student lying on back with legs raised.

Physician's Authorization: I authorize the above plan to be followed at school

Physician's Printed Name:	Signature:	Date:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

FIELD TRIPS:
- Send prescribed medications and Action Plan.
- 911 will be called, as needed

SELF-CARRY EPINEPHRINE CONTRACT

I give permission for my child, ____, to carry his/her epinephrine. My child understands that he/she must never share his/her epinephrine with others and that he/she must go to Health Services immediately after use of epinephrine. I will notify the school of changes in medication or my child's condition. **Please note: It is recommended to have a back-up epinephrine that is kept in Health Services.**

Parent/Guardian Signature ____ Date __________________________

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick the medication(s) up from the office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature ____ Date _________________________

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature ______________________________________ Date ______________________________

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at anytime in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date:

Allergy Questionnaire

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Allergy To: check appropriate box and provide specifics below

☐ Peanuts ☐ Nuts ☐ Eggs ☐ Seafood ☐ Latex ☐ Insect Stings ☐ Other

Specifics:

1. How soon after contact does your child react? _________minutes, _______hours, ________days
2. How often has your child been treated by a healthcare provider for an anaphylactic allergic reaction?

   ____
3. How many times has your child been treated with epinephrine? ________________________________
4. When was the last time that your child was treated with epinephrine? ___________________________
5. What are the early-warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction?____
6. Does your child recognize these signs/symptoms? ☐ Yes ☐ No
7. Does your child know how to avoid causes of allergic reactions? ☐ Yes ☐ No

Circle the symptoms that your child has shown during an allergic reaction:

- Mouth: itching, tingling, or swelling of lips, tongue, mouth
- Skin: hives, itchy rash, swelling of the face or extremities
- Gut: nausea, abdominal cramps, vomiting, diarrhea
- Throat: tightening of throat, hoarseness, hacking cough*
- Lungs: shortness of breath, repetitive coughing, wheezing*
- Heart: weak pulse, dizziness, fainting, pale, blueness*
- Other ____

*Potentially life-threatening

FOR FOOD ALLERGIES ONLY:

For students in grades K-5, a pictoral alert system is used in the cafeteria and for recess supervisors – where indicated.

Cafeteria Seating

Does your child need any special precautions in the cafeteria? ☐ Yes ☐ No If yes, please explain:

____

Classroom Food Management

Does your child need any special precautions in the classroom in regards to:

1. Snack ☐ Yes ☐ No
2. Classroom Parties ☐ Yes ☐ No
3. Food Used in Curriculum ☐ Yes ☐ No

If yes to any of the above questions, please explain ____

Do you feel that your child's allergy issues in school need to be addressed in more detail? ☐ Yes ☐ No

If you answer yes, a health services staff member will contact you.

Any additional comments: