Severe Allergy Packet

For Parent / Guardian

Please take one of these packets to be completed by you and the child's physician and returned to the school health aide.

Thank you!

Contents:

- Allergy and Anaphylaxis Plan and Medication Order
- Parent Questionnaire-Family Food Allergy Health History Form
- Self-Carry Contract

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

Student's Name: ______________________ D.O.B. __________ Grade: ____________

School: ______________________ Teacher: ______________________

ALLERGY TO: ____

HISTORY: ____

____

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

◊ STEP 1: TREATMENT

Symptoms	Treatment
SEVERE SYMPTOMS: Any of the following: LUNG: Short of breath, wheeze, repetitive cough THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Swelling of the tongue and/or lips HEART: Pale, blue, faint, weak pulse, dizzy SKIN: Many hives over body, widespread redness GUT: Vomiting or diarrhea (if severe or combined with other symptoms OTHER: Feeling something bad is about to happen, Confusion, agitation	1. **INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 • Ask for ambulance with epinephrine • Tell EMS when epinephrine was given 3. Stay with child and • Call parent/guardian and school nurse • If symptoms don't improve or worsen give second dose of epi if available as instructed below • Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**
MILD SYMPTOMS ONLY: NOSE: Itchy, runny nose, sneezing SKIN: A few hives, mild itch GUT: Mild nausea/discomfort	1. Stay with child and • Alert parent and school nurse • Give antihistamine (if prescribed) 2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose) ______________________________

Asthma Rescue Inhaler (brand and dose) ______________________________

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print) ______________________________ Phone Number: ______________

Provider's Signature: ______________________________ Date: ______________

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: ______________________ Phone Number: ______________________
3. Emergency contacts: Name/Relationship Phone Number(s)

   a. ______________________ 1) ____________ 2) ____________

   b. ______________________ 1) ____________ 2) ____________

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: ______________________________ Date: ______________

School Nurse: ______________________________ Date: ______________

Student Name: ______________________________ **DOB:** ____________________

Staff trained and delegated to administer emergency medications in this plan:

1.______________________________ Room ____________________

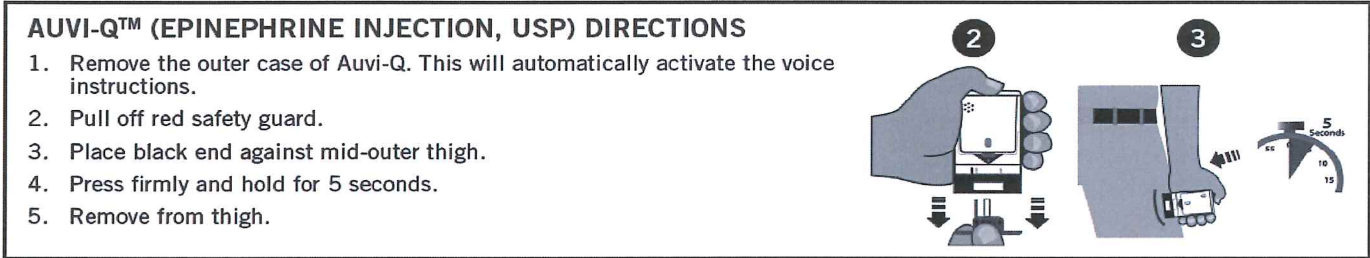
2.______________________________ Room ____________________

3.______________________________ Room ____________________

Self-carry contract on file: ☐ Yes ☐ No

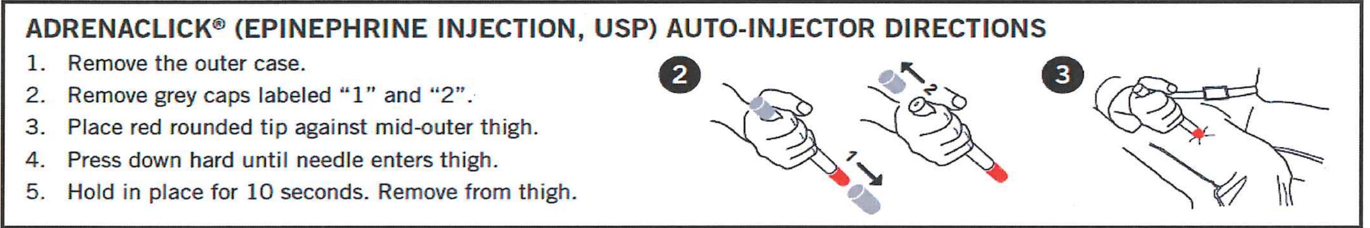
Expiration date of epinephrine auto injector: ____________________

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.



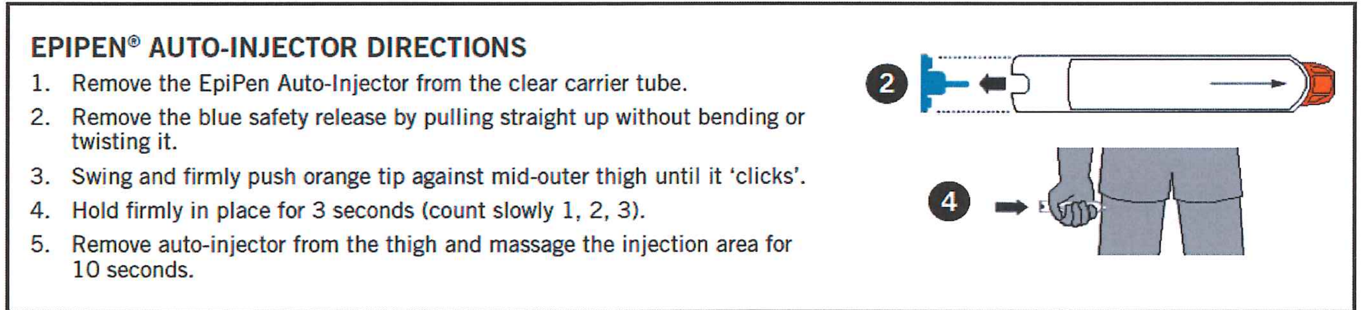
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR 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 enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it ‘clicks’.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.

If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:____

____

____

____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

Family Food Allergy Health History Form

Student Name: ____ Date of Birth: ___________________

Parent/ Guardian(s) : ____

Home Phone: _______________________ Cell: _________________________Work: ___________________________

Primary Healthcare Provider: ____ Number: _________________________

Allergist: ____ Number: _________________________

Does your child have a diagnosis of an allergy from a healthcare provider: ☐ No ☐ Yes

1) History and Current Status:

What is your child allergic to?

☐ Peanuts ☐ Eggs ☐ Milk ☐ Soy ☐ Fish/ Shellfish ☐ Tree Nuts

☐ Latex ☐ Insect Stings

☐ Chemicals _______________ ☐ Vapors ______________ ☐ Other _________________________

Age allergy was first discovered: ___________

How many reactions? ☐ None ☐ One ☐ More than once, explain: ____

Explain reaction/Symptoms:____

2) Trigger and Symptoms

What are early signs/symptoms of your child's allergic reaction: (Be specific; include things they might say)

____

____

How does your child communicate his/her symptoms:____

How quickly do symptoms appear after exposure: ____Seconds _____Minutes _____ Hours _____ Days

Please check symptoms your child has experienced in the past:

Skin:	☐ Hives	☐ Itching	☐ Rash	☐ Flushing	☐ Swelling
Mouth:	☐ Itching	☐Swelling (mouth, lips, tongue)			
Throat	☐ Itching	☐ Tightness	☐ Hoarseness	☐ Cough	
Abdominal	☐ Nausea	☐ Cramps	☐ Vomiting	☐ Diarrhea	
Lungs	☐ Shortness of breath		☐ Repetitive Cough		☐ Wheezing
Heart	☐ Weak Pulse		☐ Loss of consciousness		

3) Treatment

How have past reactions been treated? ____

How effective was your child's response to treatment? ____

Was there an Emergency Room Visit ☐ No ☐ Yes, Explain ____

What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

____

Have you used the treatment/ Medication ☐ No ☐ Yes

Please describe any side effects or problems your child had in using the suggested treatment:

____

4) Self-Care

Is your child able to monitor and prevent their own exposure? ☐ No ☐ Yes

Does your Child:

1. Know what foods to avoid ☐ No ☐ Yes
2. Ask about food ingredients ☐ No ☐ Yes
3. Read and understand food labels ☐ No ☐ Yes
4. Tell an adult immediately after an exposure ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
6. Tell peers and adults about the allergy ☐ No ☐ Yes
7. Firmly refuse a problem food ☐ No ☐ Yes

Does your child know how to use emergency medication? ☐ No ☐ Yes

Has your child ever administered their own emergency medication? ☐ No ☐ Yes

5) Family/ Home

How do you feel that the whole family is coping with your child's allergy? ______________________________

Does your child carry Epinephrine in the event of a reaction? ☐ No ☐ Yes

Has your child ever needed to administer that Epinephrine? ☐ No ☐ Yes

Do you feel that your child needs assistance in coping with their allergy? ☐ No ☐ Yes

6) General Health

How is your child's general health other than having an allergy? ______________________________

Does your child have other health conditions? ______________________________

Has your child ever been hospitalized? ______________________________

Does your child have a history of Asthma? ☐ No ☐ Yes

If yes, does your child have an Asthma Action Plan? ☐ No ☐ Yes

Please add anything else you would like the school to know about your child's health:

____

____

Parent / Guardian Signature: ______________________________ Date: ______________

Reviewed by R.N. : ______________________________ Date: ______________

Formulario de historial médico de alergia familiar

Nombre del estudiante: ___________________________ Fecha de nacimiento: __________

Padre / tutor (es): ____

Teléfono de casa: ____________________ Celular: ______________________ Trabajo: ____________________

Proveedor de atención médica primaria: __________________________________ Número: _______________

Alergólogo: ____ Número: _____________________

¿Su niño tiene un diagnóstico de alergia por un proveedor de atención médica?: • No • Sí

1) Historial y estado actual:

¿A qué es alérgico su niño?

• Cacahuetes • Huevos • Leche • Soya • Pescado / Mariscos • Nueces de árbol

• Látex • Picaduras de insectos

• Productos químicos _____________• Vapores ____________ • Otro ______________________

La edad que la alergia se descubrió por primera vez: __________

¿Cuántas reacciones? • Ninguno • Uno • Más de una vez, explique: ______________________________

Explique la reacción / síntomas: ____

2) Desencadenante y síntomas

¿Cuáles son los primeros signos / síntomas de la reacción alérgica de su hijo? (Sea específico; incluya lo que podría decir)

____

____

¿Cómo comunica su hijo su / sus síntomas: ____

Con qué rapidez aparecen los síntomas después de la exposición: ____ Segundos _____ Minutos _____ Horas _____ Días

Por favor, marque los síntomas que su hijo ha experimentado en el pasado:

Piel:	• Urticaria	• Picazón	• Sarpullido	• Enrojecimiento	• Hinchazón
Boca:	• Picazón/ Comezón	• Hinchazón (boca, labios, lengua)			
Garganta:	• Picazón/ Comezón	• Opresión	• Ronquera	• Tos	
Abdominal:	• Náuseas	• Calambres	• Vómitos	• Diarrea	
Pulmones:	• Dificultad para respirar	• Tos repetitiva	• Sibilancias		
Corazón:	• Pulso débil	• Pérdida del conocimiento			

3) Tratamiento

¿Cómo se han tratado las reacciones pasadas? _____________________________________

¿Qué tan efectiva fue la respuesta de su hijo al tratamiento? ___________________________

¿Hubo una visita a la sala de emergencias? • No • Sí, explique ________________________

¿Qué tratamiento o medicamento ha recomendado su proveedor de atención médica para usar en una reacción alérgica?

____

¿Ha usado el tratamiento / medicamento? • No • Sí

Por favor describa cualquier efecto secundario o problema que su hijo tuvo al usar el tratamiento sugerido:

____

4) Autocuidado

¿Puede su hijo controlar y prevenir su propia exposición? • No • Sí

¿Su hijo:

1.	sabe qué alimentos evitar	• No	• Sí
2.	sabe preguntar sobre los ingredientes de los alimentos	• No	• Sí
3.	sabe leer y comprender las etiquetas de los alimentos	• No	• Sí
4.	Isabe informar a un adulto inmediatamente después de una exposición	• No	• Sí
5.	Usa una pulsera, collar, correa de reloj de alerta médica	• No	• Sí
6.	sabe informe a sus compañeros y adultos acerca de la alergia	• No	• Sí
7.	sabe rechazar firmemente un alimento problemático	• No	• Sí

¿Sabe su hijo cómo usar medicamentos de emergencia? • No • Sí

¿Alguna vez su hijo ha administrado su propio medicamento de emergencia? • No • Sí

5) Familia / Hogar

¿Cómo siente que toda la familia está lidiando con la alergia de su hijo? ____________________

¿Su hijo porta epinefrina en caso de una reacción? • No • Sí

¿Alguna vez su hijo ha necesitado administrar esa epinefrina? • No • Sí

¿Cree que su hijo necesita ayuda para afrontar su alergia? • No • Sí

6) Salud general

¿Cómo se encuentra la salud general de su hijo además de tener alergia? ____________________

¿Su hijo tiene otras condiciones de salud? ____________________

¿Alguna vez su hijo ha sido hospitalizado? ____________________

¿Su hijo tiene antecedentes de asma? • No • Sí

En caso afirmativo, ¿tiene su hijo un plan de acción para el asma? • No • Sí

Por favor agregue cualquier otra cosa que le gustaría que la escuela supiera sobre la salud de su hijo:

____

____

____

____

____

____

Firma del padre / tutor: ____________________ Fecha: __________

Revisado por RN: ____________________ Fecha: __________

Allergy Self Carry Contract **School:** ______________________ **Grade:** ______

STUDENT : ________________________________ **DOB:** ____________

- ☐ I plan to keep my Epi-pen with me at school rather than in the school health office.
- ☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office immediately if my Epi-pen has been used.
- ☐ I will not allow any other person to use my Epi-pen.

Student's Signature ______________________________ Date _______________

PARENT/GUARDIAN: ______________________________

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
- ☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.
- ☐ I will provide the school a signed medication authorization for this medication.

Guardian's Signature ______________________________ Date _______________

Nurse Consultant _________________________ **School** ________________

- ☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____________________ Date _______________

School Administrator's Signature: ______________________ Date: _______________
Teacher's Signature: ______________________________ Date: _______________
Teacher's Signature: ______________________________ Date: _______________
Health Assistant Signature: __________________________ Date: _______________

Allergy Self Carry Contract **School:** ______________________ **Grade:** __________

STUDENT

☐ I plan to keep my Epi-pen with me at school rather than in the school health office.

☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-pen has been used.

☐ I will not allow any other person to use my Epi-pen.

Student's Signature ________________________________ Date ________________

PARENT/GUARDIAN

Este contrato estará en efecto el presente año escolar a menos que el doctor del estudiante lo revoque o que el estudiante falle en cumplir las contingencias propuestas en el párrafo anterior.

☐ Estoy de acuerdo en ver que mi niño/a lleve la medicación prescripta, que el dispositivo contenga medicina, y que este al día.
☐ Se me ha recomendado que un Epi-pen de emergencia sea provisto al Oficial de Salud para casos de emergencia.
☐ Revisaré el estado de las alergias del estudiante regularmente como fue aceptado en el plan de salud.
☐ Proveeré a la escuela la autorización firmada por el proveedor de salud autorizando el uso de la medicación.

Firma del padre ___________________________________ Fecha ________________

Health Office Staff

☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.
Nurse Consultant's Signature ______________________ Date ________________

School Administrator's Signature: ______________________ Date: ________________
Teacher's Signature: ________________________________ Date: ________________
Teacher's Signature: ________________________________ Date: ________________

☐ Copy Sent to District Nurse Consultant