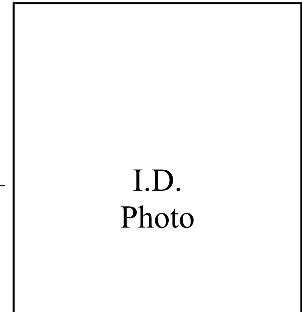
EMERGENCY ACTION PLAN
ALLERGIC REACTION



Name of Student ___ ____

Grade _________ Homeroom _____ Bus Rider (circle) YES NO Bus # ________

Allergic to: ____

ASTHMATIC (circle) *YES NO *HIGH RISK FOR SEVERE REACTION

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Mouth	Itching and swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, coughing
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	"Thready" pulse, "passing out"
Mental	Anxiety or feeling of impending doom
The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!	

ACTION:

1. Never leave child alone.
2. Give prescribed medication ________________________________
3. CALL 911 IF NO RELIEF AFTER MEDICATION.
4. CALL 911 IMMEDIATELY IF USING EPI-PEN
5. Call parent/guardian or emergency contacts.
6. Call Dr. ________________________ at __________________
7. Additional instructions ___________________________________
   ____

HOW TO ADMINISTER EPI-PEN:

1. Pull off gray safety cap.
2. Place black tip on outer thigh.
3. Push injector against thigh until unit activates, hold in place for 10 seconds.
4. Notify emergency personnel that epi-pen has been administered.

Emergency contact #1
Name ________________________ Relationship____________ Phone (h)___________ (w)____________
Emergency Contact #2
Name ________________________ Relationship____________ Phone (h)___________ (w)____________
Emergency Contact #3
Name ________________________ Relationship____________ Phone (h)___________ (w)____________
Child's Physician ____ Phone ___________________
Parent/Guardian Signature ____ Date ____________
Nurse Signature ____ Date ____________

Any revision to the student's IHP or EAP requires a new form to be completed, signed and dated by parent.

INDIVIDUALIZED HEALTH CARE PLAN
ALLERGIC REACTION

Name of Student ____

Grade ______ Homeroom _____ Bus Rider (circle) YES NO Bus # ________

Allergic to: ____

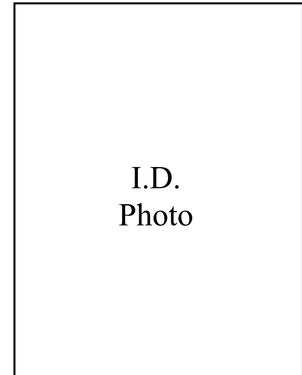
ASTHMATIC (circle) *YES NO *HIGH RISK FOR SEVERE REACTION

Accommodations needed for classroom or school environment: ____________________

____

____

____



In the event of classroom/school parties, food treats will be handled as follows:

_____ Student may eat the treat

_____ Student may take treat home

_____ Replace treat with parent supplied alternative

_____ Modify treat as follows ____

Additional instructions:

____

____

____

____

Student has an **EMERGENCY ACTION PLAN** Yes No

See EMERGENCY ACTION PLAN for “How to Administer Epi-Pen”

The following staff members have been instructed in the administration of epi-pens.

____

____

____

____

____

Parent/Guardian Signature ____ Date _____________

Nurse Signature ____ Date _____________

Any revision to the student’s IHP or EAP requires a new form to be completed, signed and dated by parent.

STUDENT WITH FOOD ALLERGY
Parent Questionnaire

Student's Name____ Grade_____ Homeroom____________
Name of Student's Doctor (for allergies)____ Ph._______________

The following information will help the school nurse and school personnel meet the health needs of your child while he/she is at school. Please answer the following questions to the best of your ability.

	Allergy #1	Allergy #2	Allergy #3
What food is your child allergic to?			
On a scale of 0-10 with 0 being "Mild" and 10 being "Severe,"how would you rate your child's food allergy?			
At what age did your child start experiencing this food allergy?			
How do you know that your child is allergic to this food?	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ Family history	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ Family history	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ Family history
When was the last time your child ate this food?			
How soon after being exposed to this food do your child's symptoms start?			
How long do you child's symptoms last?			
What symptoms does your child have when exposed to this food? (check all that apply)	☐ Itching/tingling (where __________) ☐ Swelling (where __________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe ____________________	☐ Itching/tingling (where __________) ☐ Swelling (where __________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe ____________________	☐ Itching/tingling (where __________) ☐ Swelling (where __________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe ____________________
Does your child take medication for these symptoms?	☐ No ☐ Yes- please list ____________________	☐ No ☐ Yes- please list ____________________	☐ No ☐ Yes- please list ____________________
Does your child have an Epinepherine Auto-injector prescribed?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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1. Does your child have any other allergies or asthma? (please list) ____

2. How often does your child see his/her doctor for routine allergy evaluations?__________________________________

3. When was his/her last appointment?____

4. When was your child's last episode of food allergy symptoms? ____

5. How many times has your child been treated in the ER or hospitalized for an allergic reaction? _________________

6. If prescribed, where do you want your child to keep his/her epinephrine auto-injector during the school day?
   ___ Health Office ___ With him/her

7. Has your child received education about how to recognize symptoms of allergic reaction?
   Yes_____ No _____

8. Has your child received education about how to self-administer his/her epinephrine autoinjector?
   Yes _____ No _____

9. Does your child wear a Medic Alert bracelet or something similar to identify him/her as having food allergies?
   Yes ____ No _____

10. Does your child need any special considerations related to his/her food allergy(ies) while at school? (Check all that apply and describe briefly)
    ___ Modified snacks ____
    ___ Modified lunch seating ____
    ___ Emotional or behavior concerns ____
    ___ Special considerations on field trips ____
    ___ Other ____

11. Is there anything else you would like for school personnel to know about you child's food allergy(ies)?
    ____
    ____

May this information be shared with the classroom teacher(s), bus driver(s) and other appropriate school personnel? Yes _____ No _____

If you wish to personally discuss your child's food allergy with the school nurse, you may reach the school nurse at:

Nurse's Name____ Ph.________________Days____________

If the school nurse needs to contact you to review this information please list your contact information:

Parent's Name(s)____ Ph. (H)_____________ (W)______________

____ ____________________________
Signature of Parent/Guardian Completing Questionnaire Date