This form must be updated annually

ALLERGIC or ANAPHYLAXIS 2023-24
REACTION TO INSECT STINGS/FOODS/OTHER
Questionnaire and Emergency Care Plan

Allergic to _____

Please help us to understand the details and severity of the allergy.
If this is not a severe allergy, please sign below and DISCUSS with your school nurse.

Parent/Guardian signature: _____ Date: _____

Student's name_____ Date of Birth_____ Grade/Teacher_____

Parent/Guardian_____ Day phone_____ next choice_____

Address _____ Other phone (Mom) _____ (Dad) _____

City: _____ **Physician name**_____ Phone _____

Other emergency contacts: _____ day phone _____ next choice_____

Another contact: _____ day phone _____ next choice _____

Hospital (if 911 transport) _____ **Asthmatic**? ◯YES ◯NO (If so is at higher risk for severe reaction)

1. At what age did the student have his/her first allergic reaction? _____ How many reactions has s/he had? _____
2. When was the last reaction the student experienced? _____ Does this student know what to avoid? ☐ **Yes** ☐ **No**
   Has testing at a medical clinic been done? ☐ **Yes** ☐ **No** Stinging insect shots at clinic? ☐ **Yes** ☐ **No**
3. Are there pre-warning signs (physical & emotional changes) that indicate the student may be having a reaction?

_____

a. What are the signs of actual reaction? (ie. Local swelling, respiratory difficulty) Please explain _____

_____

b. How soon after the contact does your student react? ☐ **Minutes** ☐ **hours**

c. Does the student recognize when he/she is having a reaction? (circle) ☐ **YES** ☐ **NO**

Please circle or highlight symptoms listed on the right that this student has experienced.

Throat	***Tightening of throat, hoarseness**
Lung	***Shortness of breath, repetitive coughing, wheezing**
Heart	***Fast pulse, "passing out"**
GI	Nausea, vomiting, abdominal cramps, diarrhea
Skin	Hives, itching, rash, flushing, swelling of face or extremities
Mouth	Itching, swelling of lips or mouth

The school will contact you as soon as possible if exposure to an allergic food, or sting, has occurred. The school will call 911 for continued distress, or if epinephrine is used.

4. Is there anything else you would like to add about this student's reaction (example: should be at a peanut-free lunch table)?

_____

_____

Parent/guardian: In addition, if your child's allergy if life-threatening, please contact the school's cook manager (if they ever eat school lunch), transportation department (if they ever ride the bus), and staff of after-school sports, and activities as needed. Please arrange safe accommodationsfor his/her needs. Health room staff is available only during school class hours.

Name of student _____ Date of Birth _____ Allergic to _____

This section is to be completed by physician or health care provider.
Please check appropriate boxes below for school management of allergic reaction:
If allergic reaction occurs at school notify health office immediately of exposure; student needs to remain with an adult:

STEP 1: **IDENTIFYING** a reaction

BODY SYSTEMS:	SYMPTOMS:
Throat	***Tightening of throat, hoarseness, swelling of tongue**
Lung	***Shortness of breath, repetitive coughing, wheezing**
Heart	***Fast pulse, "passing out", dizziness, pale or blue skin**
GI/gut	Nausea, vomiting, abdominal cramps, diarrhea
Skin	Hives, itching, rash, flushing, swelling of face or extremities
Mouth	Itching, swelling of lips or mouth
OTHER:	

STEP 2: **EVALUATING** emergency

- If allergic food EATEN with ANY SYMPTOMS other than mouth or hives alone:
- If allergic food NOT known to be eaten but TWO or more body systems of symptoms:
- If insect sting with spreading reaction:

1. Give EPINEPHRINE
2. Call 911.
3. Give Antihistamine
4. Re-evaluate (Step 4 below).
5. Contact parent/guardian.

- If allergic food EATEN and NO SYMPTOMS:
- If allergic food EATEN and …SYMPTOMS are only around and in mouth or only skin hives:

☐ **1. Give ANTIHISTAMINE**
2. Continue to watch person for symptoms
OR
☐ **1. Give EPINEPHRINE**
2. Call 911.
3. Give Antihistamine
4. Re-evaluate (Step 4 below).
5. Contact parent/guardian.

STEP 3: **TREATING,** dosages

EPINEPHRINE DOSE: Keep 2 doses on hand

- ☐ EpiPen Jr. (0.15 mg) IM-up to 44 lbs (20 kg)
- ☐ EpiPen (0.3 mg) IM-over 44 lbs
- ☐ Auvi-Q Jr. (0.15 mg) IM-up to 44 lbs (20 kg)
- ☐ Auvi-Q (0.3 mg) IM-over 44 lbs

ANTIHISTAMINE TYPE & DOSE:

- ☐ Benadryl (also known as Diphenhydramine)
  - ☐ 12.5 mg orally (1 tsp or 1 chewable)
  - ☐ 25 mg orally (2 tsp or 2 chewables or 1 capsule)
  - ☐ 50 mg orally (4 tsp or 4 chewables or 2 capsules)

Special circumstances:_____. ☐ See additional page.
Our district requests that prescriptions are for dual packs. Unlicensed non-medical personnel may administer the auto injector dose, & then summon EMT services.

STEP 4: **RE-EVALUATING**

Watch the person closely until transport to Emergency Department. If symptoms of throat, lung or heart are worsening, or not improving, GIVE a second dose of Epinephrine after 5 minutes.

Does the student know when medication is needed? ☐ **YES** ☐ **NO** Self-carry? ☐ **YES** ☐ **NO** Self inject? ☐ **YES** ☐ **NO**

Any other comment:_____

Physician signature _____ printed name _____ Date _____

Clinic name _____ Phone _____ Fax _____

Parent/Guardian:
Your signature below allows the above medication(s) to be given during school hours or while on field trips. You need to supply the school with the listed medications and notify the school of any changes in the above plan. Your signature gives permission for the school nurse and provider to consult about the above listed medical condition and medication. Without your signature below, school personnel are not able to administer the medication. This consent may be revoked by sending a written note to the school nurse. This information will not be released to a third party payer.

Parent/Guardian signature _____ Date _____