Little Chute Area School District

Health Services

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Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No

Health Condition: **Food Allergy**
Please List All Foods Your Child is Allergic To: _____

Asthma History: Yes _____ No _____ *Note: History of asthma increases risk of anaphylaxis.*

History of anaphylaxis/allergic reaction? Yes _____ No _____ *If yes, first line treatment for any subsequent reaction should be epinephrine.*

If yes to above, please describe signs and symptoms during reaction? _____

Has epinephrine ever been administered? Yes _____ No _____ If yes, when? _____

Emergency Procedure:

1. Give appropriate medication as listed.
2. If epinephrine is given, call 911: state had ana llergic reaction has been treated
3. Additional epinephrine may be needed. If symptoms continue, repeat epi-injector after 5-10 minutes.
4. Stay with students and monitor.
5. If self-administered, students must notify school personnel.

**Do not wait for previous symptoms noted above to appear before providing care. Subsequent exposures may look different.*

Symptoms: Give Checked Medication *(To be determined by physician authorizing treatment)*	**Administer Epinephrine**
If food allergen has been ingested, but not symptoms:	**Yes No**
Mouth: Itching, tingling, or swelling of lips, tongue or mouth	**Yes No**
Skin: Hives, itchy rash, swelling of the face or extremities	**Yes No**
Gut: Nausea, abdominal cramps, vomiting, diarrhea	**Yes No**
Throat: Tightening of throat, hoarseness, hacking cough	**Yes No**
Lungs: Shortness of breath, repetitive coughing, wheezing	**Yes No**
Heart: Thready pulse, low blood pressure, fainting, pale, blue	**Yes No**
Other: _____	**Yes No**

If reaction is progressing (several of the above areas affected)	**Yes** **No**

EMERGENCY CONTACT: Name: Phone: Relationship to student:

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

For completion by physician: Physician's Name: Phone:

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Auvi-Q™ 0.3 mg Auvi-Q™ 0.15 mg

Antihistamine: give: medication/dose/route _____

Other: give: medication/dose/route _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Is the child knowledgeable about his or her medication & need to notify school personnel if epinephrine is administered: Yes _____ No _____

Has the child demonstrated the proper technique in administering medication: Yes _____ No _____

Side effects:

( ) I have instructed _____ in the proper way to use his/her injected medications. It is my professional opinion that he/she should be allowed to carry and use this injected medication by him/herself.

( ) It is my professional opinion that _____ should not carry and use his/her injected medication by him/herself.

Physician's Signature:	**Date:**

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer Epinephrine: Yes _____ No _____

By signing you agree you have reviewed this health plan for your child and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent's Signature:	**Date:**

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Principal's Initials: _____

Food Allergies Care in School Checklist

School Year:	**Grade:**	**Teacher:**
Students Name:		**Date:**
Parent/Guardian's Name:		**Phone:**
Parent/Guardian's Name:		**Phone:**
Food Allergens:		
Allergy to (Circle those that apply):	**Ingestion Touch Aerosol**	

For PARENTS to complete	**Yes**	**No**	**Notes**
Elementary Students ONLY			
Would you like the food allergy letter sent home in your child's classroom?			
If each child brings their own snack to school daily, are there any special precautions needed in the classroom?			
If there is a special occasion treat (birthday or party) would you like to be notified? Would you like to have an alternative snack stored in the classroom or health office for your child? **Note: Teachers will do their best to notify in advance of all special occasions, but please consider having an alternative snack there at all times to help during those times in which teachers are unable to notify.*			
Would you like your child to be seated at the "Hot Lunch" table in the lunchroom? **Note: In the elementary lunchroom there is a table for students in which children can only eat hot lunch or for student with peanut allergy to eat lunches.*			
ALL Students			
Will there be Benadryl sent to school for your child?			
Will there be Epi-Injector (ie:Epipen) sent to school for your child?			

Do you feel that you would like to:

_____ Have a special meeting with the classroom teacher and school nurse
_____ Call or email the classroom teacher on my own
_____ I understand the classroom teacher will have access to this plan. No additional follow up is needed.

Anything else you would like your school nurse/school staff to know:

Feel Free to call your school nurse with any questions or concerns you may have.