EMERGENCY FOOD ALLERGY AND SEVERE ALLERGY RESPONSE PLAN (AAP)

PHOTO

TO BE COMPLETED BY PARENT:

STUDENT INFORMATION (PLEASE PRINT)

Student Name: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

EMERGENCY INFORMATION : ***INCLUDE CELL PHONE AND BEEPER #'S***

Mother/Guardian Name: _____ Father/Guardian Name: _____

Telephone (H): _____ Telephone (H): _____

Telephone (W) : _____ Telephone (W): _____

Physician Name : _____ Telephone: _____

In the event a parent/guardian cannot be reached contact:

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____

CHECK ANY SEVERE ALLERGY(IES) YOUR CHILD HAS:

- ❑ Insect Stings (List type) _____
- ❑ Food (List type) _____
- ❑ Pollens: Usual time reactions occur: _____ Spring, _____ Summer, _____ Winter, _____ Fall
- ❑ Dust
- ❑ Grass
- ❑ Animal (List type) _____
- ❑ Other (List) _____

CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK

- ❑ Difficulty Breathing
- ❑ Difficulty in Swallowing
- ❑ Loss of Consciousness
- ❑ Rash
- ❑ Nausea
- ❑ Swelling : How much? _____ Where ? _____
- ❑ Flushed or unusually pale skin
- ❑ Other (List) _____

Has hospitalization been needed in the past year for allergies ? _____ NO _____ YES (If YES) When? _____

Are medications needed for the allergy (ies) ? _____ NO _____YES (List below)

_____

****__If medication is to be given at school the Physician Order Form and a Medication Order Form must be filled out.__**

Notify Parent/Guardian in the following situations : _____

_____

Any other information:_____

My signature allows permission to include my child's picture with this plan. I give permission for my child to administer, be administered or assisted in the self-administration of the Epi-Pen by authorized persons. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider who signs the Medication Order Form regarding any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the Epi-Pen.

_____ _____

Parent/Guardian Signature Date

5/07 **(OVER)**

PHYSICIAN ORDER FORM FOR AN ALLERGY ATTACK

Student Name:_____

ALLERGY(IES) TO :_____

Asthmatic: Yes ☐ No ☐ High risk for severe reaction ☐

SIGNS OF AN ALLERGIC REACTION

Systems:	Symptoms:
• **MOUTH**	itching & swelling of the lips, tongue, or mouth.
• **THROAT**	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
• **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".

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

- **ACTION FOR PREVENTION: {Please list allergens to avoid}**_____

_____

- **ACTION FOR MINOR REACTION:**_____

1. If symptom (s) is/are :_____,give_____
   Medication/dose/route

Then call:

2. Mother _____ Father _____, or Emergency contacts.

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

- **ACTION FOR MAJOR REACTION;**

If ingestion is suspected and/or symptom(s)_____

Give_____**IMMEDIATELY!**

It is my professional opinion that above named student be allowed to carry his/her own Epi-Pen __YES___ NO.

Then call:

1. Rescue Squad
2. Mother _____ Father _____, or Emergency contacts.

******If medications are indicated, a Medication Form must be completed.**

DO NOT HESITATE TO CALL RESCUE SQUAD!

_____ _____
Date Physician's Signature

_____ _____ _____
Print Physician's Name Address Phone Number

5/07