This page to be completed by Parent/Guardian

Student Name _____ School Year_____

Child's Picture

Warren Woods Public Schools

Severe Allergy School Health Plan

Student Name_____

Date of Birth _____ Age_____ Grade ___ School_____

Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.

CONTACT INFORMATION

	Call First	**Try Second**
Parent/ Guardian:	Name:_____	Name:_____
	Relationship: _____	Relationship: _____
Phone:	Home: _____	Home: _____
	Cell: _____	Cell: _____
	Work: _____	Work: _____

Call Third (If Parent/guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? ___ Yes ___No

Does your child have Asthma? (If yes, at a higher risk for severe allergic reaction) **___ Yes ___ No**

Note: if you child needs medication at school for asthma, please complete a separate ASTHMA Medical Action Plan

List all Allergic FOOD
If nuts, please specify by circling one or both: Peanut Tree Nut

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Can student determine their own food choices at school? ___Yes ___ No

List of Different SEVERE ALLERGIES (such as, Insect Sting or Latex)

If my child is to self-carry epinephrine, I will still supply the school office with a back up auto-injector. ___ Yes ___ No

Note: Meals from home provide the safest food option at school.

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergies to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered on page 2 of this severe allergy health care plan for allergic reactions and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Source: School Based Allergy Management Plan pg 2 adopted from Food Allergy Network

This page to be completed by Physician/Licensed Provider

Student Name _____ School Year_____

Mild Symptoms (local reaction)

Mild Skin Reactions - Hives/Swelling only in the area of allergen contact

- ✓ **Students with Adrenalin (Epi-Pen) or history of Anaphylaxis must go home with parental supervision for the remainder of the school day**

SYMPTOMS CAN BECOME MOVE SERIOUS VERY QUICKLY OR OVER THE NEXT SEVERAL HOURS

Emergency Treatment

If student has mild symptoms or ingestion is suspected:

- Remove object-casing reaction, as soon as any of the above reactions are noted.
- Rinse area with large amounts of water and escort student to front office if condition permits
- Contact school administrator
- Note time _____ (am/pm) and stay with student
- **Watch closely for any serious symptoms**
- Give antihistamine if ordered by doctor
- Call Parent or Emergency Contact (current Emergency Contact information is available from the school office)
- Stay with student until Parent or Emergency Medical services arrives
- If symptoms progress give Epinephrine (see serious symptoms below)

DO NOT HESITATE TO CALL 9-1-1 OR TO GIVE EMERGENCY MEDICATIONS

SERIOUS SYMPTOMS (Systematic Reaction)

- Throat – itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- Lung – shortness of breath, repetitive coughing or wheezing
- Heart – "passing out", blueness, pale, faint, weak pulse, dizzy, confused
- Mouth – itching & swelling of the lips, tongue, or mouth
- Skin – hives, itching rash, and/or swelling about the face or extremities
- Gut – nausea, abdominal cramps, vomiting and/or diarrhea

Or **combination** of symptoms from different body areas:
Skin: Hives, itchy rashes, swelling (e.g. eyes, lips)
Gut: Vomiting, crampy pain

Emergency Treatment

IF STUDENT HAS ANY SERIOUS SYMPTOMS:

- Note time _____ am/pm and stay with student
- Give _____ as ordered by doctor
- **ADMINISTER EPI PEN** injection, if ordered
  Follow direction on injection device as trained
  Note time given: _____ am/pm
- **Call 9-1-1**
- Dispose of used Epi-pen in safe, needle proof container and give to Emergency responders
- Give copy of "Emergency Action Plan" to emergency responders
- Call Parent or Emergency Contacts (current emergency contact information is available from the school office)

Monitoring
Stay with student; call 911 and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. For severe reaction, consider keeping student lying on back with legs raised. Keep head to the side if vomiting. Treat student even if parents cannot be reached.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Epinephrine dose ___.15 mg (junior) ___ .3 mg (adult) Auto injector brand name if known_____
Two doses are to be made available at school ___ Yes ___ No
If yes, second dose may be given 5 minutes or more after the first if symptoms persist or recur.

It is my professional opinion that student should self-carry epinephrine ___Yes ___No

NOTE: If a student is to self-carry their epinephrine, help may still be needed to give the medication.

Antihistamine name_____ **Dosage** (please do not give a range) _____

Other instructions or orders _____

Physician/licensed prescriber name _____

Phone number _____ **Fax number** _____

Signature _____ **Date** _____