



ALLERGIC or ANAPHYLAXIS 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 call your school nurse to discuss. Parent/Guardian signature: _____ Date: _____

Student's Name _____ Date of Birth _____ Grade/Teacher _____
Parent/Guardian _____ Day phone _____ Cell _____
Home Address: _____ Other phone (Mom) _____ (Dad) _____
City: _____ Physician Name _____ Phone _____
Other Emergency Contacts: _____ Day Phone _____ Cell _____
Another contact: _____ Day Phone _____ Cell _____
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? (check) Yes No

Please circle or highlight symptoms listed on the right that this student has experienced. * Indicates life-threatening symptoms

- 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 is life-threatening, please contact the school's cook manager (if they ever eat school lunch), transportation department (if they ride the bus), and staff of after-school sports, activities or Adventure Club, as needed. Please arrange safe accommodations for his/her needs. Health room staff is available only during school day class hours.

This section is to be completed by physician or health care provider, or clinic's Allergy Action Plan submitted.

Please check appropriate boxes 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 (circle or highlight ones student has exhibited):
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)
 50 mg orally (4 tsp or 4 chewables)

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**

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 _____