CHILTON PUBLIC SCHOOL DISTRICT – CONFIDENTIAL HEALTH INFORMATION

ALLERGY HEALTH ACTION PLAN

Student Name ____

Date of Birth ______________________ Weight __________ Age ___________________

School year____________________________ Teacher/ HR ________________________Grade:____________

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____________________ H/C/W Name/ Relationship_______________________________________

Phone 2. _____________________ H/C/W Name/ Relationship_______________________________________

Phone 3. _____________________ H/C/W Name/ Relationship_______________________________________

ALLERGY:____

Physician student sees for Allergy _____________________________________ Phone _______________

Asthmatic: Yes_____ No _____ (If yes, student has higher risk for a severe reaction)

(If food allergy) My child has a reaction when he/she:

- ❑ Eats a food or another food containing the food allergen
- ❑ Touches a surface contaminated with oils from the food allergen
- ❑ Breathes odors from the food allergen while food is being cooked or processed

Check the symptoms your child has during a severe allergic reaction:

- ❑ Hives/rash ❑ Tightness in Chest ❑ Difficulty Breathing ❑ Nausea and vomiting ❑ Dizziness
- ❑ Itching ❑ Swelling arms/legs ❑ Unconsciousness ❑ Cramping and abdominal pain
- ❑ Flushed face ❑ Drooling ❑ Swelling of lips, tongue, nose or throat
- ❑ Hacking cough ❑ Other: ____

Onset of Symptoms after ingestion or contact:

❑ Immediately ❑ Within 15 minutes ❑ Within an hour ❑ Within 2 hours ❑ Varies/Unknown

If you will provide meals and snacks, explain: ____
____

Does your child require an antihistamine at school? Yes___ No___ Location: _______________________

Medication/Dose____

Does your child require Epinephrine at School? Yes____ No____ Location: ____________________

Can your child self-administer epinephrine in school? Yes____ No____

Has your child ever needed epinephrine before? Yes___ No____

Explain: ____
____

Any other special considerations for school? ____
____

NOTE: Parents are responsible for providing medication given at school. A Medication Authorization Form will need to be filled out and signed by a parent/guardian and health care provider annually.

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

EMERGENCY ACTION PLAN- STEPS TO TAKE DURING AN ALLERGIC REACTION

	SEVERE SYMPTOMS
LUNG	Short of Breath, wheezing, repetitive cough
HEART	Pale, blue, faint, weak pulse, dizzy
THROAT	Tight, hoarse, trouble breathing/swallowing
MOUTH	Significant swelling of the tongue and/or lips
SKIN	Many hives over body, widespread redness
GUT	Repetitive vomiting or severe diarrhea
OTHER	Feeling something bad is about to happen, anxiety, confusion * OR a combination of mild or severe symptoms from different body areas.

EMERGENCY PROCEDURE

1. **For any of the listed SEVERE symptoms, INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911**. Tell the rescue squad epinephrine was given. Request ambulance with epinephrine.
3. Consider giving additional medications (following or with the epinephrine): Antihistamine, Inhaler (bronchodilator) if asthma
4. Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, a second dose of epinephrine can be given 5 minutes or more after the last dose.
6. Alert emergency contacts (parent/guardian).
7. If stung by insect, apply ice to the site.

	MILD SYMPTOMS
NOSE	Itchy/runny nose, sneezing
MOUTH	Itchy mouth
SKIN	A few hives, mild itch
GUT	Mild nausea/discomfort

PROCEDURE

1. **When in doubt, give epinephrine.**
2. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN.**
3. Stay with student; alert emergency contacts.
4. If stung by insect, apply ice to the site.
5. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE**.

EMERGENCY MEDICATIONS:

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

Side effects: ______________________________

Antihistamine name: ______________________ Dose: ______________ Route: ______________

Side effects: ______________________________

Other (ex. inhaler): medication/dose/route ______________________________

Health Care Provider Signature: ______________________________Date:______________________

Parent/Guardian Signature: ______________________________ Date: ______________________

School Nurse: ______________________________ Date: ______________________

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips. Please note that for the safety of the student, all staff members will be made aware of the student's allergy.

Memo of Understanding:

- It is the mutual responsibility of parent & teacher to review party / field trip menus and make arrangements.
- It is the responsibility of the parent to review breakfast and lunch menus with their child.
- It is understood that students are not allowed to share food or eating utensils at school.
- It is understood that a parent will complete and sign a Food Allergy Health Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the nurse of any changes in the health plan.