

RANDOLPH SCHOOL DISTRICT – CONFIDENTIAL HEALTH INFORMATION

ALLERGY HEALTH ACTION PLAN**Student Name** _____ **ALLERGY:** _____

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.

EMERGENCY ACTION PLAN- STEPS TO TAKE DURING AN ALLERGIC REACTION

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

	MILD SYMPTOMS	<u>PROCEDURE</u>
NOSE	Itchy/runny nose, sneezing	When in doubt, give epinephrine. GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN. - Stay with student; alert emergency contacts. - If stung by insect, apply ice to the site. - Watch student closely for changes. If symptoms worsen, GIVE EPINEPHRINE.
MOUTH	Itchy mouth	
SKIN	A few hives, mild itch	
GUT	Mild nausea/discomfort	

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 the 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.