

**Student Allergy History Form**

Student:	School:	Effective Date:
Date of Birth:	Grade:	Teacher:

Please note: Food Allergy and Anaphylaxis Emergency Care Plans must be submitted annually at the beginning of each school/SACC year dated after May 1, and whenever modifications are made to this plan.

**To be Completed by Parent/Guardian**

Contact Information		
Parent/Guardian #1:		
Address:		
Telephone – Home:	Work:	Cell:
Parent/Guardian #2:		
Address:		
Telephone – Home:	Work:	Cell:
Emergency Contact #1:		
Telephone – Home:	Work:	Cell:
Emergency Contact #2:		
Telephone – Home:	Work:	Cell:
Health Care Provider's Name:	Office Phone:	
Medical History		
What is your child allergic to?		
What age was your child when diagnosed?		
Has your child ever had a life-threatening reaction?		
What is your child's typical allergic reaction?		
Does your child have asthma?		
Does your child know what food/allergens to avoid?		
Will your child eat the school provided breakfast and/or lunch?		
Will you be providing meals and snacks for your child at school/SACC?		
How does your child travel to school/SACC?		
<input type="checkbox"/> Bus #	<input type="checkbox"/> Car	<input type="checkbox"/> Walk



# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

**PLACE  
STUDENT'S  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**








**Extremely reactive to the following allergens:** \_\_\_\_\_

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for ANY symptoms. **Call 911.**
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent. **Call 911**

FOR ANY OF THE FOLLOWING:





## SEVERE SYMPTOMS

 <b>LUNG</b> Shortness of breath, wheezing, repetitive cough	 <b>HEART</b> Pale or bluish skin, faintness, weak pulse, dizziness	 <b>THROAT</b> Tight or hoarse throat, trouble breathing or swallowing	 <b>MOUTH</b> Significant swelling of the tongue or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	OR A <b>COMBINATION</b> of symptoms from different body areas.

↓ ↓ ↓

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. 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, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy or runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea or discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE. AND CALL 911.**

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**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

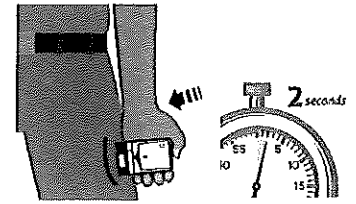


# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

3



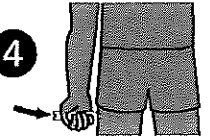
## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

3



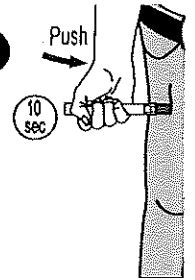
4



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

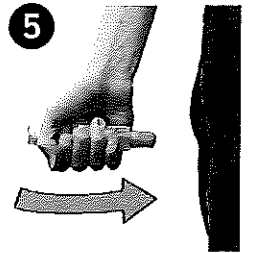
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## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### DESIGNATED SCHOOL/CCC STAFF TRAINED ON STUDENT'S ALLERGY ACTION PLAN

Printed Name	Signature	Printed Name	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of School Nurse

Date

**PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION  
FOR ALLERGIC REACTIONS**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Schools must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian this written informed consent gives trained school/Child Care Contractor (CCC) staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school/School Age Child Care (SACC) such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented until all signatures have been obtained. Legally appropriate school health professional-medical prescriber communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student's academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

The student may not attend school until the written parental/guardian authorization has been signed and returned to the school.

In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board, any of its employees, or CCC liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

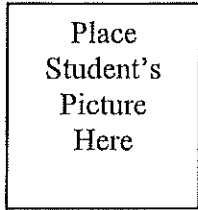
\_\_\_\_\_  
Print Parent's/Guardian's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

Prince William County Public Schools  
Severe Allergy Individual Health Care Plan



Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Lunch Time: \_\_\_\_\_

Classroom

- Any food given to student must be approved by parent/guardian.
- Emergency food provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects involving food should be reviewed by the parent/guardian and the teaching staff.
- Middle school or high school student will be making his/her own decision:  YES  NO

Bus

- Transportation will be alerted to student's allergy.
- This student has a physician's order to carry epinephrine on bus:  YES  NO
- Epinephrine can be found in:  backpack  waist pack  other (specify) \_\_\_\_\_
- Student will sit at front of bus:  YES  NO

Field Trip Procedures

- Parent/guardian should be notified of field trips as early as possible.
- Epinephrine should accompany student during any off-campus school sponsored activity.
- The elementary student should remain with the teacher during the entire field trip:  YES  NO
- Middle school/high school student should remain with the teacher during the entire field trip:  YES  NO

Cafeteria

- Food Service Manager and cafeteria hostesses will be alerted to the student's allergy.
- Cafeteria tables where food allergic students eat will be cleaned to eliminate food allergens.
- Student will sit at a specified allergy table:  YES  NO
- Student will sit at the classroom table at a specified location:  YES  NO
- NO restrictions where student may sit in the cafeteria:  YES  NO

Students should use their account cards (at elementary) or student identification number (at middle and high school) to identify their allergy. The cafeteria menu is available online. Parents/guardians are encouraged to make food choices from the menu. The complete list of menu ingredients can be accessed through the School Food and Nutrition Services website.

\_\_\_\_\_  
Parent's/Guardian's Signature Date

\_\_\_\_\_  
School Nurse's Signature Date

\_\_\_\_\_  
School

**PERMISSION FOR STUDENT TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, as the health care provider, certify that this child has a medical history of severe allergic reaction and has been trained in the use of the prescribed medication and is judged to be capable of carrying and self-administering epinephrine. The nurse or designated school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medication with others and has agreed to refrain from this practice. I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

- Self-carry  
 Self-administer

\_\_\_\_\_  
Student Signature                      Print Student Name                      Date

\_\_\_\_\_  
Health Care Provider Signature      Print Health Care Provider Name      Date

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\_\_\_\_\_  
Parent's/Guardian's Signature                      Date

\_\_\_\_\_  
Principal/Designee Signature                      Date