School Year: _____

Teacher: _____

Grade: _____

NEWHALL SCHOOL DISTRICT

SEVERE ALLERGY ACTION PLAN

Emergency Care Plan

Place Student's Picture Here

Name: _____ D.O.B: ____/____/____

Allergy to: _____

Reactions previously noted: _____

Current Weight: _____lbs. **Asthma: ☐Yes (higher risk for a severe reaction) ☐ No**

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- ✓ **Difficulty breathing, wheezing, or repetitive cough**
- ✓ **Swelling of face, neck, or tongue**
- ✓ **Tightness in throat, hoarseness, drooling, or difficulty swallowing.**
- ✓ **Pale, blue, faint, weak pulse, dizzy, confused**
- ✓ **Vomiting, diarrhea, crampy abdominal pain**

1: **INJECT EPINEPHRINE IMMEDIATELY**
2: Call 911
3: Begin monitoring (see box below)
4: May give additional medications (if ordered):
- Antihistamine
- Inhaler (bronchodilator) if asthma

5: Give second dose of epinephrine after 5 minutes if severe symptoms persist

MILD SYMPTOMS ONLY:

- ✓ **Red, watery eyes**
- ✓ **Itchy, runny nose, sneezing**
- ✓ **Rash, hives, redness or swelling of localized area**
- ✓ **Itching, tingling mouth, throat, or tongue WITHOUT OTHER SYMPTOMS**

1: **GIVE ANTIHISTAMINE**
2: Stay with student; alert healthcare professionals and parent
3: If symptoms progress (see above), **USE EPINEPHRINE**
4: Begin monitoring (see box below), parent must pick student up.

Medications/Doses:

Epinephrine (brand): _____ ☐ 0.15 mg ☐ 0.3mg

Antihistamine (brand): _____ ☐12.5 mg ☐25mg ☐50mg ☐___ mg every ☐ 4hrs ☐ 6hrs

Other (e.g., inhaler-bronchodilator if asthmatic)(brand): _____ puffs every ☐ 4hrs ☐ 6hrs

Possible Side Effects: _____

MONITORING

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. **For a severe reaction**, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See Epinephrine for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature Date Physician Signature Date

Printed/ Stamped Physician Name and Phone Number: _____

Parent/Guardian Contact Information:

1st Contact Phone# Alt phone #

2nd Contact: _____ Phone# _____ Alt phone # _____

I would like my child to sit at a peanut-free table: ☐ YES ☐NO

Rev. 6/2017

NEWHALL SCHOOL DISTRICT

FAMILY SEVERE ALLERGY HEALTH HISTORY FORM

Student Name:_____ Date of Birth:_____

Parent/Guardian:_____ Today's Date:_____

Home Phone:_____ Work:_____ Cell:_____

Healthcare Provider:_____ Phone:_____

Allergist:_____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider? No☐ Yes ☐

2. History and Current Status:

a. What is your child allergic to?

☐	Peanuts	☐	Insect Stings
☐	Eggs	☐	Fish/Shellfish
☐	Milk	☐	Chemicals
☐	Latex	☐	Vapors
☐	Soy	☐	Tree Nuts(walnuts, pecans etc)

1.

Other: _____

b. Age of student when allergy first discovered:_____

c. How many times has student had a reaction?

☐ Never ☐ Once ☐ More than once, explain:

_____

d. Date of last reaction: _____

e. Date of last ER visit: _____

f. Are the food allergy reactions: ☐ Same ☐ Better ☐ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms and your student's allergic reaction? (Be specific; include things the student might say.) _____

_____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure? _____secs._____mins. _____hrs._____days

d. Please circle the symptoms that your child has experienced in the past:

Skin:	Hives	Itching	Rash	Flushing	Swelling (face, arms, hands, legs)
Abdominal:	Nausea	Cramps	Vomiting	Diarrhea	
Throat:	Itching	Tightness	Hoarseness	Cough	
Mouth:	Itching	Swelling (lips, tongue, mouth)			
Lungs:	Shortness of breath		Repetitive Cough		
Heart:	Weak Pulse		Loss of consciousness		

4. Treatment

a. How have past reactions been treated? _____

b. Was there an emergency room visit? ☐ No ☐ Yes, explain: _____

c. What treatment or medication had your healthcare provider recommended for use in an allergic reaction?

_____

d. Have you used the treatment or medication? ☐ No ☐ Yes

e. Please describe any side effects of the treatment: _____

_____

5. Self Care

a.	Is your student able to monitor and prevent their own exposures?	☐ No	☐ Yes	☐ Usually
b.	Does your student:			
	1. Know what foods to avoid?	☐ No	☐ Yes	
	2. Ask about food ingredients?	☐ No	☐ Yes	
	3. Read and understands food labels?	☐ No	☐ Yes	
	4. Tell an adult immediately after an exposure?	☐ No	☐ Yes	
	5. Wear a medical alert bracelet, necklace, or watchband?	☐ No	☐ Yes	
	6. Tell peers and adults about the allergy?	☐ No	☐ Yes	
	7. Firmly refuses a problem food?	☐ No	☐ Yes	
c.	Does your child know how to use emergency medication?	☐ No	☐ Yes	
d.	Has your child ever administered their own emergency medication?	☐ No	☐ Yes	

6. Family/Home

a.	How do you feel that the whole family is coping with your student's food allergy?	☐ Good	☐ Fair	☐ Poor
b.	Does your child carry epinephrine on their person in the event of a reaction?	☐ No	☐ Yes	☐ Usually
c.	Has your child ever needed to self-administer that epinephrine?	☐ No	☐ Yes	
d.	Does the parent carry epinephrine in the event of a reaction?	☐ No	☐ Yes	☐ Usually
e.	Has the parent ever needed to administer epinephrine?	☐ No	☐ Yes	

f. Do you feel that your child needs assistance in coping with his/her allergy?_____

_____

Helpful websites: www.foodallergy.org; www.aanma.org; www.medicalert.org

7. General Health

a. How is your child's general health other than having a severe allergy?_____

b. Does your child have other health conditions? _____

c. Hospitalizations? _____

d. Does your child have a history of asthma? ☐ No ☐ Yes

1. If yes, does he/she have an inhaler at school? ☐ No ☐ Yes

e. Please add anything else you would like the school to know about your child's health:_____

_____

_____

☐ **I understand information about my child's allergy will be shared with staff and food service as needed.**

Parent/Guardian Signature:_____ **Date:**_____

Notes:_____

_____

Reviewed by R.N.:_____ **Date:**_____