# FOR

# THE

# PARENT

# Spring Branch Independent School District
## HEALTH SERVICES

### SBISD Anaphylaxis Management Protocol

**SBISD takes very seriously, the health and welfare of each student. Our records indicate that your child has a potentially severe allergy that may require treatment at school. Below is a list of the required forms needed to give us the necessary information from your doctor to authorize and treat your child during an emergency. All forms must be filled out each school year. If you feel that your child's allergy does not require medications or an allergy action plan and an allergic reaction occurs at school we may need to call 911 to assure your child's safety.**

- **Anaphylaxis/Food Allergy Action Plan. Available on SBISD website by choosing Student Health/Health Services. Click on Forms and then SBISD Anaphylaxis Management Protocol.**

- **FOOD ALLERGIES only: ***Physician's diet modification form for Nutrition Services. Available in Spanish. Must be signed by parent and physician. Form is required for food substitutions to be made in cafeteria. Dietician will work with school nurse and cafeteria manager at your school to provide a monthly menu.**

- **Provide all medications indicated in Allergy/Anaphylaxis Action Plan. Provide 2 epinephrine injectors. Check with your doctor on brand name of over the counter histamines that are recommended. Make sure to provide asthma medication if your child has asthma and included in allergy action plan.**

**The school nurse will follow SBISD guidelines for treatment of Food allergies. SBISD guidelines are accordance with House Bill 1322 passed during the 81st Regular Legislative Session in 2009, the following classroom resources are being provided for teachers to use in addressing individual student health needs.**

http://www.tea.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147508170&libID=2147508161

Resources for Parents: http://www.allergyhome.org/practical-food-allergy-management-preparedness/

*****Student will not be denied food in cafeteria or modification made to student's menu until the diet modification form has accepted by Child Nutrition Services.**

# Spring Branch Independent School District

## NOTIFICATION OF A LIFE THREATENING FOOD ALLERGY IN THE CLASSROOM

Date: _____ __

Dear Parent/Guardian:

A student in your child's classroom has a life-threatening allergy to _____. Please do not send any food treats with any products listed above as an ingredient or by product . Many nonfood items can be used in the classroom to celebrate events. If you have questions, please call the nurse at: _____ __

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Notificación de una Alergia a los Alimentos ( Spanish)

Querido Padre/Tutor:

Un estduiante en el salon de clases de su hijo(a) padece una alergia a _____que presenta un riesgo a su vida. Por favor no envíe ningún alimento o merienda que contenga los ingredients ya mencianados para evitar alguna reaccion alergica.

Se pueden utilizer artículos en vez de alimentos para celebrar eventos en el salón de clases. Si usted tiene preguntas, por favor llame a la enfermera de la escuela al: _____

# FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

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

**Extremely reactive to the following foods:** _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

## 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, severe diarrhea

**OTHER**
Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

**NOSE**
Itchy/runny nose, sneezing

**MOUTH**
Itchy mouth

**SKIN**
A few hives, mild itch

**GUT**
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

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: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

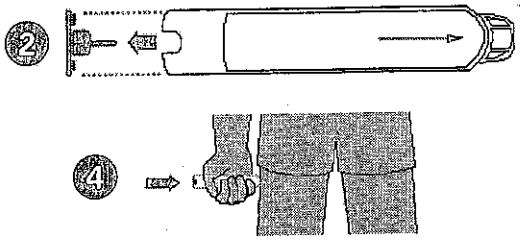
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

# FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

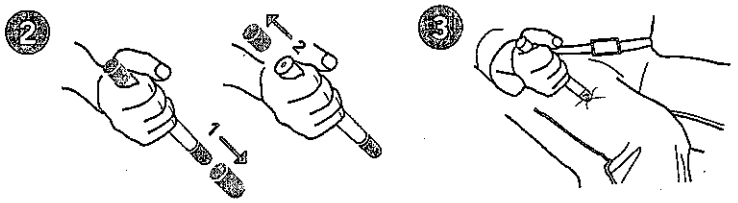
## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



## ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



**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 get worse quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

# PLAN DE ATENCIÓN DE EMERGENCIA EN CASO DE ALERGIA A ALIMENTOS Y ANAFILAXIA

FARE (Food Allergy Research & Education)

COLOQUE LA IMAGEN AQUÍ

Nombre: _____ Fecha de nacimiento: _____

Alergia a: _____

Peso: _____ libras Asma: [ ] **Sí (mayor riesgo de reacción grave)** [ ] **No**

**NOTA: No dependa de agentes antihistamínicos ni inhaladores (broncodilatadores) para tratar una reacción grave. USE EPINEFRINA.**

**Extremadamente reactivo a los siguientes alimentos:** _____

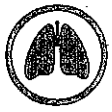
ENTONCES:

[ ] Si esta opción está marcada, administre epinefrina inmediatamente en caso de que se presente CUALQUIER síntoma si existe la posibilidad de que se haya ingerido el alérgeno.

[ ] Si esta opción está marcada, administre epinefrina inmediatamente si definitivamente se ingirió el alérgeno, incluso si no hay síntomas.

PARA **CUALQUIERA** DE LOS SIGUIENTES:

## SÍNTOMAS GRAVES



**PULMONES**
Falta de aire, sibilancia, tos reiterada

**CORAZÓN**
Palidez, color azulado, desmayos, pulso débil, mareo

**GARGANTA**
Oclusión, voz ronca, dificultad para respirar/ tragar

**BOCA**
Hinchazón significativa de la lengua y/o los labios

**PIEL**
Muchas ronchas en el cuerpo, enrojecimiento generalizado

**INTESTINO**
Vómitos reiterados o diarrea grave

**OTRA ÁREA**
Sensación de que algo malo sucederá, ansiedad, confusión

**O UNA COMBINACIÓN**
de síntomas de diferentes áreas del cuerpo.

1. **INYECTE EPINEFRINA INMEDIATAMENTE.**
2. **Llame al 911.** Comuníqueles que el niño presenta un cuadro de anafilaxia y puede necesitar epinefrina a su llegada.

- Considere administrar más medicamentos luego de la epinefrina:
  - » Agentes antihistamínicos.
  - » Inhalador (broncodilatador) si hay sibilancia.
- Recueste al niño, levántele las piernas y manténgalo abrigado. Si tiene problemas para respirar o vomita, hágalo sentarse o recostarse sobre un lado.
- Si los síntomas no mejoran, o regresan, pueden administrarse más dosis de epinefrina aproximadamente 5 minutos o más después de la última dosis.
- Avise a los contactos de emergencia.
- Lleve al niño a la sala de emergencias incluso si los síntomas desaparecen. El niño debe permanecer en la sala de emergencias durante más de 4 horas porque los síntomas podrían volver a manifestarse.

## SÍNTOMAS LEVES

**NARIZ**
Picazón/ secreción nasal, estornudos

**BOCA**
Picazón bucal

**PIEL**
Algunas ronchas, picazón leve

**INTESTINO**
Náuseas leves/ molestias

PARA **SÍNTOMAS LEVES** DE **MÁS DE UNA** DE LAS DIFERENTES ÁREAS DEL CUERPO, ADMINISTRE EPINEFRINA.

PARA **SÍNTOMAS LEVES** DE **UNA ÚNICA ÁREA** DEL CUERPO, SIGA LAS INDICACIONES A CONTINUACIÓN:

1. Se pueden administrar antihistamínicos, si así lo indica el médico.
2. Quédese con el niño; avise a los contactos de emergencia.
3. Observe detenidamente para detectar cambios. Si los síntomas empeoran, administre epinefrina.

## MEDICAMENTOS/DOSIS

Marca de epinefrina: _____

Dosis de epinefrina: [ ] 0.15 mg por vía intramuscular
[ ] 0.3 mg por vía intramuscular

Agente antihistamínico de marca o agente antihistamínico genérico: _____

Dosis del agente antihistamínico: _____

Otro (p. ej., broncodilatador inhalable si hay sibilancia): _____

_____

FIRMA DE AUTORIZACIÓN DEL PADRE/MADRE/TUTOR LEGAL FECHA

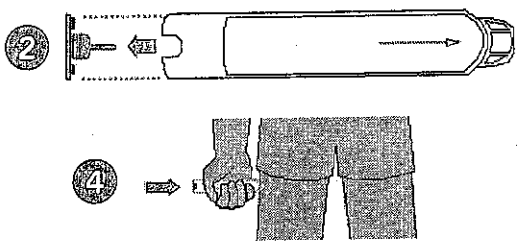
FIRMA DE AUTORIZACIÓN DEL MÉDICO/PROVEEDOR DE ATENCIÓN MÉDICA FECHA

FORMULARIO PROPORCIONADO COMO CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

# FARE
Food Allergy Research & Education

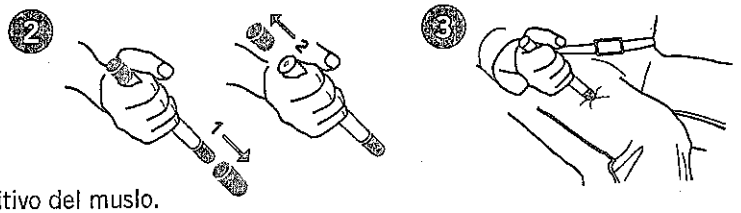
# PLAN DE ATENCIÓN DE EMERGENCIA EN CASO DE ALERGIA A ALIMENTOS Y ANAFILAXIA

## EPIPEN® (EPINEFRINA) INDICACIONES PARA EL AUTOINYECTOR



1. Retire el autoinyector EpiPen del estuche plástico.
2. Retire la tapa de seguridad azul.
3. Gire y presione firmemente la punta naranja en dirección a la parte exterior media del muslo.
4. Mantenga oprimido durante aproximadamente 10 segundos.
5. Retire el dispositivo y masajee el área durante 10 segundos.

## ADRENACLICK®/ADRENACLICK® GENÉRICO INDICACIONES



1. Retire el estuche.
2. Retire las tapas grises marcadas como "1" y "2".
3. Coloque la punta redondeada roja contra la parte exterior media del muslo.
4. Presione con firmeza hasta que penetre la aguja.
5. Mantenga oprimido durante 10 segundos. Retire el dispositivo del muslo.

**OTRAS INDICACIONES/INFORMACIÓN** (la epinefrina se puede llevar consigo; se puede autoadministrar, etc.):

Administre el tratamiento antes de llamar a los contactos de emergencia.
Los primeros signos de una reacción pueden ser leves, pero pueden empeorar rápidamente.

## CONTACTOS DE EMERGENCIA: LLAME AL 911

EQUIPO DE RESCATE: _____

MÉDICO: _____ TELÉFONO: _____

PADRE (MADRE)/TUTOR(A): _____ TELÉFONO: _____

## OTROS CONTACTOS DE EMERGENCIA

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

FIRMA DE AUTORIZACIÓN DEL PADRE/MADRE/TUTOR LEGAL FECHA

FORMULARIO PROPORCIONADO COMO CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

School Year _____--_____ Return to School Nurse and Fax to Child Nutrition Services at 713-251-1170

Spring Branch Independent School District

Child Nutrition Services will make every effort to identify possible allergens in the food we serve including providing tools such as published menus and Allergen Charts. However, students and parents must assume final responsibility for making safe food choices and knowing which food items contain which allergens. If you have any questions, please contact CNS at 713-251-1150.

# Student Diet Modification Form

Student's Name (Last, First):_____ Date of Birth:_____

School:_____ Student ID#: _____ Grade/Teacher: _____

If there are any changes to food allergy, please have physician complete form. If there are no changes, please mark the box, sign and return to school nurse. NO CHANGES ☐

***I give Child Nutrition Service and/or School Nurse permission to speak with the Physician listed below to discuss the dietary needs described on this form.***

_____ Date: _____

Parent/Guardian Signature

Phone Number: _____ Email: _____

The U.S. Department of Agriculture School Meals Program requires that **ALL QUESTIONS BE ANSWERED** in order for **ANY** diet modification or substitution to be made in school meals.

**Which meals will the student eat from the school cafeteria?** (check all that apply)

☐ Breakfast ☐ Lunch ☐ None (***if student does not eat from the cafeteria, modifications will not be arranged)***

Does the child have a **life-threatening food allergy**? **(check box)** ☐ **No** ☐ **Yes** **(If yes, Physician completes section A)**

Does the child have a **Disability requiring diet modification**? **(check box)** ☐ **No** ☐ **Yes** **(If yes, Physician completes section B)**

**Sections A and/or B to Be Completed By A Licensed Physician or Authorized Medical Professional**

**Section A: Life-Threatening Food Allergy. Only Life Threatening Allergies, where Epi Pens have been prescribed, will result in Modification. If no Modification is needed, Identification of foods can be provided by Allergen Chart and Menu. Spring Branch ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below.**

**Life-Threatening Food Allergy** (check all foods to be omitted from diet):

☐ Eggs ☐ Fish ☐ Peanuts ☐ Shellfish ☐ Soy ☐ Tree nuts ☐ Wheat

☐ Milk (severe lactose intolerance) ☐ Milk (casein/whey allergy) ☐ Other:

Specify:_____

Can the student consume foods where the allergen is an **ingredient** in a product (please specify)? ☐ Yes ☐ No

(i.e. Can consume eggs in baked goods, but not scrambled eggs)

Explain:_____

**Safe Food Substitutes:** _____

**Section B: Disability**

**Disability:** _____

**Major life activity affected** by the disability (check all that apply):

☐ Breathing ☐ Seeing ☐ Speaking ☐ Performing manual tasks ☐ Learning

☐ Eating ☐ Hearing ☐ Walking ☐ Caring for one's self ☐ Other:_____

**Type of Diet:** ☐ Regular ☐ Soft Mechanical ☐ Chopped ☐ Blended ☐ Pureed ☐ Other:_____

Name of Licensed Physician (print): _____

Physician's Signature: _____

Address: _____ Date:_____ Phone:_____

Ano Escolar _____-_____

Regrese la forma a le enfermera de la escuela y mándelo por Fax a Child Nutrition Services al 713-251-1170

Spring Branch Independent School District

Child Nutrition Services hará todo lo posible para identificar posibles alérgenos en los alimentos que servimos incluyendo herramientas como los menú publicados y informacion alérgenica. Sin embargo, los estudiantes y los padres deben asumir la responsabilidad final de la elección de alimentos seguros y saber qué alimentos contienen alérgenos. Sin tiene cualquier pregunta, por favor de llamar a la Oficina de Nutrición al 713-251-251-1150.

# Forma de Modificación Dietética

Nombre del Estudiante (Apellido, Primer):_____Fecha de Nacimiento: _____

Escuela:_____ Numero de ID#: _____ Grado/Maestro: _____

Si hay cualquier cambio en la alergia de alimento, el doctor necesita llenar el formulario. Si no hay ningún cambio, por favor de marque la casilla, firme y regréselo a la enfermera de la escuela. ☐ NO HAY CAMBIOS

***Yo le doy a Child Nutrition Services y/o la enfermera de la escuela permiso para hablar con el medico que aparece a continuación para discutir las necesidades dietéticas descritas en este formulario.***

_____ Fecha: _____

Firma del Padre/Guardian

Numero de Teléfono: _____ Email: _____

El U.S. Department of Agriculture School Meals Program requiere que TODAS LAS PREGUNTAS SE CONTESTEN para que cualquier modificación dietetica o la sustitución que se puede hacer en las comidas escolares

**Cuales comidas de la cafeteria de la escuela comera el estudiante?** (marque todo lo que corresponda)

☐ Desayuno ☐ Almuerzo ☐ Ninguno (***Si el estudiante no come en la cefeteia, no se organizaran modificacines )***

El niño tiene una alergia a los alimentos **potencialmente ponga su vida en riesgo**? (marque una casilla) ☐ **No** ☐ **Si**

**(Si marqo Si, El Medico necesita llenar Section A)**

El niño tiene una discapacidad que **requiere modificación de la dieta**? **(marque una casilla)** ☐ **No** ☐ **Si**

**(Si marqo Si, El Medico necesita llenar Section B)**

**Secciones A y/o B Para ser completado por un médico o profesional médico autorizado**

**Sección A: Alergia que pone la vida en riesgo. Solo alergias que ponen la vida en riesgo, donde la pluma EPI ha sido recetada, resultara en una modificación a la dieta. Si una modificación no es necesitada, la identificación de comidas puede ser proporcionada por los menús públicos y información alergénica.**

Spring Branch ISD no puede honrar este documento **a menos que las sustituciones específicas sean marcadas**.(Marque todas las comidas que necesitan ser omitidas):

☐ Huevos ☐Pescado ☐ Cacahuates ☐ Mariscos ☐ Soja ☐ Nueces de Arbol ☐ Trigo

☐ Leche (severa intolerancia a la lactosa) ☐ Leche (caseína / alergia de suero) ☐ Otro:

Especifico: _____

Puede el estudiante consumir alimentos donde el alérgeno es un **ingrediente** de un producto? (Por favor especifica)

☐ Yes ☐ No (por ejemplo, Puede consumir huevos en productos horneados, pero no huevos revueltos)

Explicar: _____

**Sustitutos de alimentos :** _____

**Sección B: Discapacidad**

**Discapacidad:** _____

**Actividad importante de la vida** afectada por la discapacidad (marque todo lo que corresponda):

☐ Respiración ☐ Viendo ☐ Hablando ☐ Realización de tareas manuales ☐ Aprendizaje

☐ Comiendo ☐ Oyendo ☐ Caminando ☐ El cuidado de uno mismo ☐ Otro: _____

**Tipo de Dieta:** ☐ Regular ☐ Blandita ☐ Picado ☐ Mezclado ☐ Puré ☐ Otro: _____

Nombre del médico con licencia (imprimir): _____

Firma del Medico: _____

Dirección: _____ Fecha: _____ Telefono: _____

National Association of School Nurses

# Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Today's Date: _____

Home Phone: _____ Work: _____ Cell: _____

Primary 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.) |
| ☐ 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. Explain their past reaction(s): _____

e. Symptoms: _____

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

3. **Trigger and Symptoms**

a. What are the early signs and symptoms of 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 to food(s)? _____secs. _____mins. _____hrs. _____days

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

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

4. **Treatment**

a. How have past reactions been treated? _____

b. How effective was the student's response to treatment? _____

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

d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____

e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____

f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

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

h. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. **Self Care**

a. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes

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, 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? _____

b. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

c. Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes

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

7. **General Health**

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

b. Does your child have other health conditions? _____

c. Hospitalizations? _____

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

If yes, does he/she have an Asthma Action Plan? ☐ No ☐ Yes

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

_____

8. Notes:

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

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

*Adapted with permission – Washington State Guidelines for Anaphylaxis*