CARRY CLINIC BOTH

Hamilton Southeastern Schools

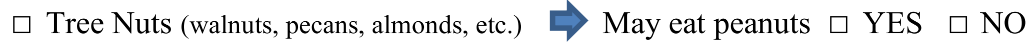
SEVERE ALLERGY -- HEALTH HISTORY

Student Name:____ School Year:______________

Date of Birth: ___________________ Teacher/Team/Grade____________________________________

1. Allergic to:

☐ Peanuts ➡ May eat tree nuts ☐ YES ☐ NO


☐ Tree Nuts (walnuts, pecans, almonds, etc.) ➡ May eat peanuts ☐ YES ☐ NO

☐ Milk/Dairy (baked/cooked ok YES/NO) ☐ Fish/Shellfish ☐ Soy ☐ Wheat ☐ Bee/wasp ☐ Latex

☐ Egg (baked/cooked ok YES/NO) Other: _____________________________

a. I give my child responsibility for choosing food items they purchase from the cafeteria ☐ YES ☐ NO

b. I will contact the cafeteria manager because my child requires special alerts/restrictions for food ☐ YES ☐ NO

2. Severity of the allergy: (circle one)

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

3. Symptoms: (please check all symptoms that your child has experienced in the past)

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, hands, arms, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Abdomen: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Cough ☐ Hoarseness

Lungs: ☐ Wheezing ☐ Shortness of breath ☐ Repetitive cough

Heart: ☐ Weak pulse ☐ Loss of consciousness

Comments/other:____

4. Able/willing to communicate their symptoms to an adult: ☐ YES ☐ NO

5. Treatment: ☐ No treatment required ☐ Antihistamine (Benadryl) ☐ Nebulizer (breathing) treatment

☐ Inhaler ☐ EpiPen (Epinephrine) ☐ Other:______________________________

6. Other health concerns:

a. Asthma ☐ YES ☐ NO

b. Other health conditions ☐ YES ☐ NO

If yes, please list____

My child has permission to transport his/her medication back home when no longer needed in the clinic or at the end of the school year: *☐ YES ☐ NO*

By signing this form, I authorize permission for this information to be shared with any school personnel who would be responsible for my child during the school day.

____ ______________________________

Printed name Phone #

____ ______________________________

Signature Date

Hamilton Southeastern Schools

CARRY CLINIC BOTH

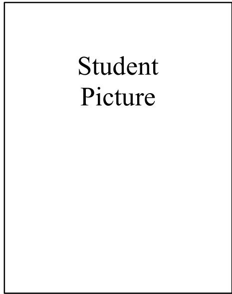
SEVERE ALLERGY -- PHYSICIAN ORDERS

STUDENT NAME: ____ Date of Birth:______________
Teacher/Team/Gr:______________________

ALLERGY TO: ☐ **PEANUT** ☐ **TREE NUT** ☐ **FISH/ SHELLFISH** ☐ **WHEAT**

☐ **MILK/DAIRY** ☐ **EGG** ☐ **SOY** ☐ **BEE/WASP** ☐ **LATEX**

☐ **OTHER**____



ASTHMA: ☐ YES ☐ NO Check ***IF*** student takes: ☐ Beta-Blocker ☐ Ace Inhibitor ☐ Alpha-Blocker

****This student can safely eat in the school cafeteria** ☐ **YES** ☐ **NO**

****For this student's health/safety, eating at an allergy safe table is:** ☐ **Mandatory** ☐ **Not Required**

If student has ONE OR MORE SEVERE SYMPTOMS:
-LUNG: Short of breath, wheeze, repetitive cough
-HEART: Pale, blue, faint, weak pulse, dizzy, confused
-THROAT: Tight, hoarse, trouble breathing/swallowing
-MOUTH: Obstructive swelling (tongue and/or lips)
-SKIN: Many hives over body
-GUT: Vomiting, diarrhea, cramping pain
OR
COMBINATION of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 9 1 1.
3. Begin monitoring (see below).
4. Give additional medications:
   - Antihistamine
   - Inhaler (bronchodilator)

*Antihistamines & bronchodilators are not to be depended upon alone to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

If the student has MILD SYMPTOMS:
-MOUTH: Itchy mouth
-SKIN: A few hives around mouth/face, mild itch
-GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; call parent and/or physician.
3. *If symptoms progress,* ***INJECT EPINEPHRINE.***
4. Begin monitoring (see below).

MONITORING: Stay with student; contact parent and call 911 to notify epinephrine was given and the time given. Treat student even if parent cannot be reached. Keep student lying on back with lower legs/feet elevated.

This student is extremely reactive to the above allergens; give epinephrine IMMEDIATELY if allergen was likely OR definitely eaten, EVEN IF NO SYMPTOMS ARE NOTED. ☐ YES ☐ NO ________MD initials

MEDICATIONS: Epinephrine (brand & dose)____

Antihistamine (brand & dose)____

Other (inhaler/bronchodilator if asthmatic)____

**Student may carry epinephrine OR inhaler while at school: ☐ YES ☐ NO

- -

As a healthcare provider licensed in the State of Indiana, I have reviewed the orders above with the patient's parent/guardian and they understand the orders as written.

____ ____________________
Physician Signature/Printed Date

As parent of above student, I understand and agree to HSE's school policy/procedure that states if epinephrine is given, 911 will be called and the student will be transported to the emergency room for evaluation. By signing this form, I authorize permission for any of the above information to be shared with any school personnel who would be responsible for my child during the school day.

____ ________________
Parent/Guardian Signature Date

____ ____________________________________
Parent /Guardian printed name Phone number