DEPARTMENT OF SCHOOL HEALTH SERVICES

Danville Independent Schools

TO: Parent/guardian of:_____
Date of birth:_____
Enrolled in grade_____
Attends _____school

You have checked on school records that this student has a **severe or serious allergy**. It is important to have at least annual health information when s/he needs help at school. **Please complete this form and return it** to the school nurse **tomorrow** so a plan to help your child can be shared with identified school personnel. It is the **responsibility of parents** to provide necessary special food and medicine needed at school. If you have any questions, you may call the nurse at the student's school or the school health office at the number above.

CHECK ANY LIFE THREATENING ALLERGY YOUR STUDENT HAS:

A – [] insect stings (list type)_____

B- [] food (list type)_____

C- [] animals (list type)_____

D- [] other (list)_____

INDICATE THE SIGNS THAT ARE USUALLY PRESENT DURING ALLERGY ATTACK by placing letter(s) of allergies checked above by the symptoms listed below.

_____difficulty breathing

_____difficulty swallowing

_____loss of consciousness

_____swelling:

how much?_____

where?_____

_____rash

_____nausea

_____flushed or unusually pale skin

_____other (list)_____

_____

Has emergency medical treatment been needed in the past year for allergies? [] No [] Yes
(when):_____

Allergies are currently being treated by Dr. :_____

ARE MEDICATIONS NEEDED TO CONTROL THE ALLERGY (IES)? [] No [] Yes (list below)

Medications	Amount taken	Time of Day

(Turn page over)

Do any of these medications need to be taken at school? [] no [] yes

Which one(s)?_____* (see below)_____

_____

PLEASE ADVISE THE SCHOOL NURSE AT ONCE OF ANY CHANGES IN DOSE AND/OR TYPE OF MEDICATION

THE USUAL TREATMENT AT SCHOOL FOR A STUDENT HAVING A SEVERE ALLERGIC REACTION IS TO:

1. Assist student with the prescribed medication.
2. Observe the student for inadequate breathing; signs of shock; unusual swelling. If any of these signs are present, 9-1-1 will be called.
3. Report to parent.

If you want additional help given, or have other concerns, describe here; ** (see below)

_____

_____

_____

_____

X_____

Parent Signature Date

Remember to advise the school immediately of changes in phone numbers, address, responsible emergency contact persons, doctor, hospital preferences.

- * Your district has a policy regarding taking medicines at school. Please check with your child's school for direction.
- ** Tests and activity restrictions require written directions from the student's doctor.

Name: _____ D.O.B.: _____

Allergy to: _____

Wt: _____ 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: _____

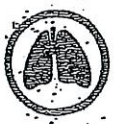
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue 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 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

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or 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 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): _____

_____

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

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