INDIVIDUAL FOOD ALLERGY WORKSHEET

The information you provide will be the basis on which your child's school health plan will be written. It will be used to educate ALL staff about your child's specific signs/and symptoms. It does not take the place of any other document in this packet. This information should be updated yearly, more often if there are changes.

STUDENT NAME _____ GRADE____

1. Name all foods or food additives to which your child is allergic. Contact sensitivity vs. ingestion, or both?

2. Describe the reaction your child has exhibited in the past when exposed to the allergen. (contact and ingestion)

3. What ways does your child describe his/her symptoms?

4. Will you be available to attend class trips with your child? If applicable, will your child go home for lunch, or eat in our lunchroom? Is he/she permitted to buy the school lunch (not recommended) or ice cream?

Please use the remainder of this space to list any additional information or concerns you may have:

Food Allergy Action Plan

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

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.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

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

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

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

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

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

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)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

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. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

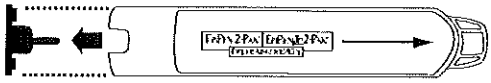
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

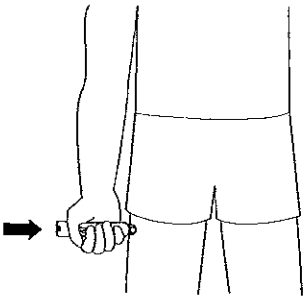
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



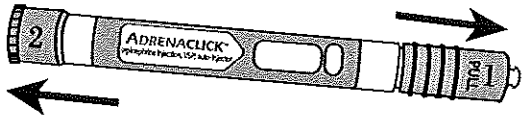
- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

PITMAN SCHOOL DISTRICT

PARENT REQUEST

EMERGENCY ADMINISTRATION OF EPINEPHRINE
P.L. 1997, C.368 NJSA 18A:40-12.5 & 12.6

Child's Name: _____
(Please Print)

Parent's/Guardian's Name: _____
(Please Print)

Date: _____

I/We request and give authorization for the administration of a pre-filled, single dose auto-injector mechanism containing ***Epinephrine*** by the School Nurse or a delegate who has been trained and is CPR certified.

I/We acknowledge that if procedures specified in the NJSA 18A:40-12.5 are followed, the district shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing ***Epinephrine*** to my/our child and that I/We shall indemnify and hold harmless the district and its employees against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing ***Epinephrine*** to my/our child.

_____
Parent/Guardian Signature

PITMAN PUBLIC SCHOOLS
MEDICATION PERMISSION REQUEST FORM

To Parents/Guardians:

The Pitman School District requires that all students who need medication during school hours must provide the following:

- Present a written consent form signed by the parent or guardian
- Present a written form signed by the physician, describing medication, dosage and diagnosis
- Parent must bring the medication in the original prescription container, properly labeled by the pharmacist, to school

Name of Student_____

D.O.B._____ School_____ Grade_____

TO BE COMPLETED BY PHYSICIAN:

Name of Medication_____

Specific time(s) and dose(s) to be given at school_____

_____

Length of time_____

Are there any restrictions? ___Yes ___No If yes, please explain_____

_____

_____

_____ _____

Printed Name of Physician Signature of Physician

TO BE COMPLETED BY PARENT/GUARDIAN:

I, _____, give permission for my child _____ to receive the above medication as directed by my physician.

_____ _____

Date Parent/Guardian Signature

_____

Telephone Number

PITMAN SCHOOL DISTRICT

Date: _____

Dear _____,

Your request for the selection of a delegate to provide emergency care to _____ has been completed.

A delegate has been chosen for the school year _____. The lay-person employee of the Pitman Board of Education is _____.

This individual has agreed to be trained in the administration of a pre-filled, single dose auto-injector of ***Epinephrine***, to be CPR certified and to assume the responsibility of providing the care needed when the training has been completed.

You have the responsibility and right to agree or disagree with the selected delegate.

Please sign and return the lower portion of this letter to me as soon as possible with the option you prefer.

Thank you,

_____
School Nurse

_____I/We agree to and request that _____, administer, in an emergency situation, a pre-filled single dose auto-injector of ***Epinephrine*** to our child _____.

_____ I/We do not agree to the chosen delegate _____, to administer a pre-filled, single dose auto-injector of ***Epinephrine*** to our child _____. Please select another delegate.

_____
Parent/Guardian Signature

_____
Parent/Guardian Signature