1 Student Drive
Eastampton, NJ 08060

Eastampton Community School
School Health Services

Phone: 609-267-9172
Fax: 609-261-3338

ALLERGY QUESTIONAIRE / HISTORY

Dear Parent/Guardian of _____,

You have indicated that your child has a food allergy. Please assist us by answering the following questions and providing some history. If extra space is needed, please use the back of the page.

1. Please list specific items to which your child is allergic. Describe their reaction or symptoms and also indicate if the reaction occurs when the allergen is smelled, touched, ingested, or all of the above.

Allergen	Reaction / Symptoms	Smell	Touch	Ingest

2. Please list **all foods and ingredients** that must be omitted from your child's diet. Include any dietary precautions that are followed at home. _____

3. If an allergen is accidentally smelled, touched or ingested at home, what is done? _____

4. Does your child know what food/ingredients they can not eat? _____ Yes _____ No

5. Does your child ever try to eat any food/ingredients that cause an allergic reaction? _____ Yes _____ No

7. Does your child require any specific accommodations in the cafeteria? _____ No _____ Yes
If yes, please explain. _____

If lunch menu restrictions or accommodations are required, we recommend that you to also contact the cafeteria directly.

8. Is it acceptable for your child to be sitting close to, or at the same table with, another child who may be eating a food to which your child is allergic? _____ Yes _____ No *(Doctors orders will be required.)*

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8. Has you child ever had a **physician documented** anaphylactic experience involving respiratory distress?

_____ No _____ Yes If yes, please explain. _____

_____

_____

What symptoms did your child have to the allergen and how soon after contact with the allergen?

_____ Mouth Itching, tingling, or swelling of lips, tongue, mouth _____

_____ Skin Hives , itchy rash, swelling of face or extremities _____

_____ Gut Nausea, abdominal cramps, vomiting, diarrhea _____

_____ Throat Tightening of throat, hoarseness, hacking cough _____

_____ Lung Shortness of breath, repetitive coughing, wheezing _____

_____ Heart Weak or thready pulse, low blood pressure, fainting, pale, blueness _____

_____ Other _____

What did the physician need to do and what medications were given in response to the reaction? _____

_____

_____

Please check one:

_____ My child **does not** require emergency medication to be kept at school.

_____ **My child's allergy requires emergency medication at the school. I understand that I must supply the medication along with signed orders from my child's physician. (Forms available from the school, and must be renewed each school year.)**

_____

Parent / Guardian Signature Date

Thank you very much for taking the time to answer all of these questions. The nurse's office will use this information to assist in caring for your child, and to determine if an Allergy Action Plan is recommended. Information will be shared with teachers and other staff members as needed. Please feel free to contact us with any questions or concerns.

Sincerely,

Catherine Alderman, RN
School Nurse K-4

Mary Ostaszewski, RN
School Nurse 5-8

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ALLERGY ACTION PLAN

Place Child's Picture Here

Student's Name: _____

D.O.B. _____ Asthmatic: _____ No _____ Yes *(Higher risk for severe reaction)*

Allergy to:	Smell	Touch	Ingest
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Lunch Room Accommodations
___ No special seating.
___ Seating at separate table.
___ Unable to eat in cafeteria.

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
▪ If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly _____
medication/dose

Antihistamine: give _____
medication/dose

Other: give _____
medication/dose

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

____ Student is capable and has been instructed in the proper method of self-administering the medications named above.
____ Student is <u>not</u> approved to self-medicate.

I hereby authorize the school nurse, or equal, to administer the above ordered medication(s) to my child, as needed. In addition, I authorize any delegated school district employee to administer the pre-filled auto-injector epinephrine (eg. EpiPen or Twinjet) to my child, as needed in an emergency. I understand that this delegation is provided in order to meet provisions of N.J.S.A. 18A:40-12.3-12.6. I understand that these DELEGATES are authorized ONLY to administer the epinephrine, as needed in an emergency. I understand that the delegates are not medical personnel, but have been in-serviced in the proper administration technique by the school nurse. In the interest of my child's health, I also understand that the above medical information may be shared in confidence with delegates and/or appropriate school personnel.

Parent/Guardian's Signature _____ Date _____

Physician's Signature _____ Date _____ *(Physician's Stamp)*

Physician's Phone Number _____

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◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

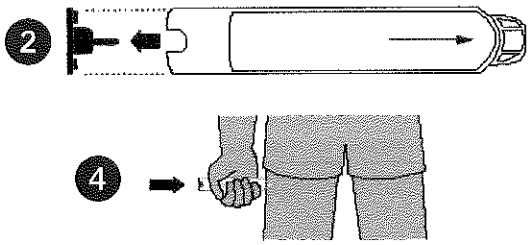
4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

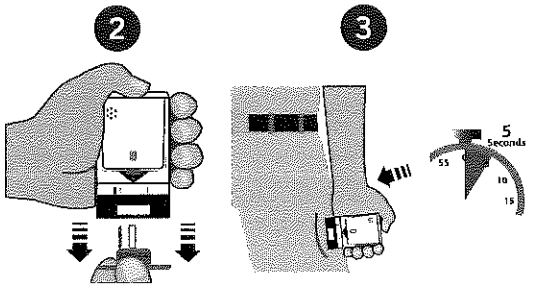
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



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.