Assessment Form: Allergy

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

Date_____

Grade/Teacher_____

Dear Parent/Guardian of _____
Our records show that your student has allergies. Help us in our efforts to provide appropriate care by completing this form and returning it to the school nurse's office.

School Nurse: Claire Wake RN, CSN Email: cwake@eaaecs.org

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Parent/Guardian Name: _____ Phone: _____
Allergy doctor's name: _____ Phone: _____
When is your student most affected by allergies? (circle any applicable)

Fall Winter Spring Summer

What is yout student allergic to? (circle any applicable)

Milk Animal dander Trees/grass/pollens Molds
Bee stings Dust Tree nuts Peanuts
Latex Medicines (specify): _____
Other: _____
Comments: _____

Please check all allergy symptoms that your student experiences:

[ ]	Stuffy, runny, itchy nose	[ ]	Persistent coughing
[ ]	Sneezing	[ ]	Wheezing
[ ]	Rash/Hives	[ ]	Dark circles under eyes
[ ]	Pale appearance	[ ]	Breathing through mouth
[ ]	Tiredness	[ ]	Headaches
[ ]	Irritability	[ ]	Severe, extensive swelling
[ ]	Anaphylactic shock reaction		
[ ]	Other: _____		

Comments: _____
How often does your student see the doctor due to allergies? _____
What medical treatment has been provided for these allergies? _____
_____
What medications does your student use?
Medication: _____ Dose: _____ How often? _____
Will your student need medication at school for the allergic reaction? Yes___No____

If yes, please have their doctor complete the attached allergy action plan, return it to the school nurse and arrange for medication drop-off.

Parent/Guardian Signature: _____ Date: _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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 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): _____

_____

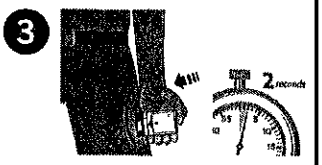
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

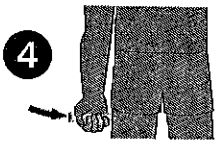
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



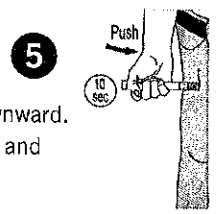
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

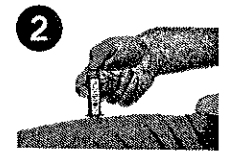


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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 worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS PROCEDURE

Dear Parents/Guardians:

We urge parents to refrain from bringing prescription and over-the-counter (OTC) medications to school unless it is absolutely necessary during school hours. If unavoidable, we **MUST** have the proper Authorization For Medication During School Hours form completed and signed by both the parent/guardian and physician, or medication will not be given. The Pennsylvania Nurse Practice Act forbids the administration of medication by RNs and LPNs without direct authorization from a licensed physician. If your child must take medication at school, the procedure is as follows:

1. An Authorization For Medication During School Hours form is required from the family physician, which shall indicate the necessity of the medication(s) being given to the child during school hours, the name of the medication, the time it is to be given, the dose, and possible reaction(s), if any. This must be done for all prescription, over-the-counter (OTC) medications/remedies, herbal or homeopathic supplements, oils, and/or vitamins.
2. The Authorization For Medication During School Hours form and written statements from physicians are only good for one school year. If the dose or time of the medication changes during the school year, a new form will be required. Forms are available in the nurse's office.
3. Medication is to be brought to school by a parent/guardian in the original pharmacy container and delivered to the school nurse. The container must be labeled with the student's full name, name of physician, dosage of medication to be given, and time when it is to be given. If this procedure is not followed, the medication will not be given. **Do not send medication to school with your child. If your child brings medication to school, it will not be given.**
4. The first dose of any new medication will not be given in school for your child's safety. If this procedure is not followed, the medication will not be given.
5. Students are expected to come to the health room to take their medication at the required time.
6. **A nurse will not be attending any field trips.** If your child needs medical attention during a field trip, teachers and chaperones will care for the child and emergency services will be called if necessary. If any medications are needed during this time, please make arrangements for a parent/guardian to chaperone, so that they may administer the medication themselves.
7. All student medication remaining in the health room at the end of the school year must be picked up by the parent/guardian. If this procedure is not followed, any remaining medication will be discarded.

EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To: School Nurse

Date: _____

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medication in an appropriately labeled, original pharmacy container, as well as all over-the-counter (OTC) medication my physician has ordered.

Name of medication: _____

Prescribed dosage: _____

Time schedule: _____

Physician name (please print): _____

Physician telephone number: _____

List of side effects of medication: _____

Diagnosis and necessity of medication during school hours: _____

_____

Expected duration of medication regime: _____

The student is excused from these activities while taking this medication:

Physical Education: _____ Other: _____

PHYSICIAN SIGNATURE: _____

As the parent/guardian, I do hereby release, discharge, and hold harmless, Easton Arts Academy and its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

PARENT/GUARDIAN SIGNATURE: _____

The student may carry his/her rescue **inhaler / Epi-Pen and has demonstrated that he/she can properly self-administer and accepts full responsibility for the administration of his/her emergency medication.

Prescriber/Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____