Hamilton Southeastern Schools

SEVERE ALLERGY HEALTH HISTORY

Student Name: _____ School Year: _____

Date of Birth: _____ Teacher/ Team/ Grade: _____

1) Allergic to:

- ☐ Peanuts Only (May eat tree nuts: YES NO)
- ☐ Tree Nuts like almonds, walnuts, pecans (May eat peanuts: YES NO)
- ☐ Milk/ Dairy (baked/cooked OK YES/NO)
- ☐ Egg (baked/cooked OK YES/NO)
- ☐ Fish/ Shellfish
- ☐ Soy
- ☐ Wheat
- ☐ Bee/Wasp
- ☐ Latex
- ☐ Other: _____

I give my child responsibility for choosing food items they purchase from the cafeteria

☐ Yes ☐ No

I will contact the cafeteria manager because my child requires special alerts/restrictions

☐ Yes ☐ No

2) Severity of Allery (Circle One)

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

3) Symptoms (please circle all symptoms 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 options:

- ☐ No treatment required
- ☐ Antihistamine (Benadryl)
- ☐ Nebulizer (breathing) treatment
- ☐ Inhaler
- ☐ EpiPen (Epinephrine)
- ☐ Other

6) Other Health Concerns (circle one):
Asthma: YES NO
Other: YES NO If YES, please list: _____

My Child has permission to transport his/her medication back home when no longer needed in the clinic/ at the end of the school year (circle): 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 Number: _____

Signature: _____ Date: _____

Hamilton Southeastern Schools

SEVERE ALLERGY PHYSICIAN ORDERS

Student Name: _____ DOB: _____
Teacher/ Team/ Grade: _____
ALLERGY TO:

- ☐ PEANUT
- ☐ TREE NUT
- ☐ FISH/SHELLFISH
- ☐ WHEAT
- ☐ MILK/DAIRY
- ☐ EGG
- ☐ SOY
- ☐ BEE/WASP
- ☐ LATEX
- ☐ OTHER: _____

Asthma: _____YES _____NO
**This student can safely eat in the cafeteria: ____YES _____NO
**For this student's health/safety, eating at an allergy safe table is: _____MANDATORY _____Not Required

One or more SEVERE symptoms	INJECT EPINEPHRINE IMMEDIATELY
Lung: Short of breath, wheezing, repetitive cough Heart: Pale, blue, faint, weak pulse, dizzy, confused Throat: Tight, hoarse, trouble breathing/swallowing Mouth: Obstructive swelling (tongue or lips) Skin: Many hives over body Gut: Vomiting, diarrhea, cramping pain OR COMBINATION of symptoms from different body areas.	1. Call 911 after injecting with Epinephrine 2. Begin monitoring (see below) 3. Give additional medications: Antihistamines, Inhaler (bronchodilator) *Antihistamines & bronchodilators are not to be depended upon alone to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS	GIVE ANTIHISTAMINE
Mouth: Itchy mouth Skin: A few hives around mouth/face or mild itch Gut: Mild nausea/discomfort	1. Stay with Student; call parent and/or physician 2. If symptoms progress, **inject Epinephrine** 3. Begin monitoring student (see below)

MONITORING THE STUDENT: stay with the student, contact the 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): _____
**This 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.

Printed Name: _____ Phone Number: _____

Signature: _____ Date: _____