Food Allergy Action Plan

New Kent County Public Schools

Questionnaire/ Permission Form

JHCF-R2 (Form 2)

Student: ____ Date of Birth: ________________

School: __________________________ Homeroom Teacher: ________________ Grade: _____

Contact Information (To be completed by Parent/ Guardian):		
Parent/ Guardian Name #1:		
Address:		
Telephone (Home):	Work:	Cell:
Parent/ Guardian Name #2:		
Address:		
Telephone (Home):	Work:	Cell:
Emergency Contact Name and Relationship:		
Address:		
Telephone (Home):	Work	Cell:
Physician treating severe allergy:		**Office:**
Please answer the following questions :		
1. What is your child allergic to?		
2. What age was your child when diagnosed?		
3. Has your child ever had a life-threatening reaction?		☐ Yes ☐ No
4. What is your child's typical allergic reaction?		
5. Does your child have asthma?		☐ Yes ☐ No
6. Does your child know what food/ allergens to avoid?		☐ Yes ☐ No
7. Does your child recognize symptoms of his/ her allergic reaction?		☐ Yes ☐ No
8. Will you be providing meals and snacks for your child at school?		☐ Yes ☐ No
9. Will your child always eat the school provided breakfast and/ or lunch?		☐ Yes ☐ No
10. How does your child travel to school?	☐ Bus # _____ ☐ Car ☐ Walk	

I give permission to the school nurse and designated school personnel to perform and carry out the tasks outlined in my child's Food Allergy Action Plan as ordered by the physician. I understand that I am to provide all supplies necessary for the treatment of my child's allergy at school. I also consent to release of information contained in this plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent's Name: ________________________________

Parent's Signature: ____________________________ Date: ____________

School Nurse's Name: __________________________

School Nurse's Signature: _______________________ Date: ____________

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Student's Photo

Name: ______________________________ DOB: ______________

Allergy to: ____

Weight: __________ lbs. Asthma: ☐ No ☐ Yes (higher risk for a severe reaction)

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 SYMPTONS after suspected or known ingestion:
One or more of the following:
LUNG: Short of breathe, 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, 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)

DOSAGE

Epinephrine: inject intramuscularly (check one)
☐ EpiPen®
☐ EpiPen® Jr.
☐ Twinject ® 03. Mg
☐ Twinject ® 0.15 mg

Antihistamine: give ______________________________
Medication, dose, route

Other: give ______________________________
Medication, dose, route

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

PLEASE NOTE: A physician's order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.

INSTRUCTIONS FROM PHYSICIAN:

☐ I have instructed this student in the proper use of his/her emergency medication for anaphylaxis. This student should be able to carry and use this medication at school independently.

☐ This student needs assistance using his/her emergency medication for anaphylaxis in school.

____

Physician Signature | Phone Number | Date

PARENT PERMISSION:

By signing this form, I give permission for the school to use the above plan to manage my child's allergy. The school may contact my child's physician regarding their allergy. I understand that I may request to meet with the counselor to discuss educational accommodations that may be needed in the school setting.

____

Parent Signature | Date | RN Signature | Date

CONTACTS:

Call 911

Doctor: ______________________________ Telephone: ____________________

Parent/ Guardian: ______________________________ Telephone: ____________________

Parent/ Guardian: ______________________________ Telephone: ____________________

Other Emergency Contacts:

Name/ Relationship: ______________________________ Telephone: ____________________

Name/ Relationship: ______________________________ Telephone: ____________________

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 reoccur. 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.

Trained Staff Members:

1. ______________________________ **2.** ______________________________

3. ______________________________ **4.** ______________________________

Name: ______________________ DOB: ______________

School: ______________________ Grade: ______________

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self- administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

☐ Self-Carry

☐ Self-Administer

______________________ ______________________ ______________

Healthcare Provider Signature Print Healthcare Provider Name Date

Parent/Guardian Response

In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student’s possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

______________________________ ______________

Parent/Guardian Signature Date

______________________________ ______________

Student Signature Date