Physician Order/Severe Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ **D.O.B:**_____ **Grade:**_____

ALLERGIC TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT (This section to be completed by authorizing physician)

Symptoms: **Give Checked Medications**

- If exposure to allergen (e.g., sting, food ingested), but has no symptoms ☐ Epinephrine ☐ Antihistamine

MILD SYMPTOMS

• Mouth	Itchy runny nose, sneezing	☐ Epinephrine ☐ Antihistamine
• Skin	A few hives, mild itch	☐ Epinephrine ☐ Antihistamine
• Gut	Mild nausea/discomfort	☐ Epinephrine ☐ Antihistamine

SEVERE SYMPTOMS - Potentially Life-Threatening

- Throat — Tightening of throat, hoarseness, hacking cough
- Lung — Shortness of breath, repetitive coughing, wheezing
- Heart — Weak pulse, faint, pale, blue, dizzy
- Gut — Repetitive vomiting, severe diarrhea
- Skin — Many hives over body, widespread redness
- Other _____

INJECT EPINEPHRINE IMMEDIATELY

The severity of symptoms can quickly change. When both Epinephrine and Antihistamine are checked, **Epinephrine will be given first**. Antihistamine or other med given only if student alert and able to swallow.

DOSAGE

Epinephrine: Inject intramuscularly (**check one**) ☐ Epinephrine 0.15mg ☐ Epinephrine 0.3 mg

Antihistamine: give _____ **Other**: give _____
Medication/dose/route Medication/dose/route

Physician's Signature_____Start Date: _____*End Date: _____
(Required)

Physician's name (printed) _____ Phone _____ Fax number _____

☐ **This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine**:

Physician's Signature and Date	Parent Signature and Date	Student's Signature and Date

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____ _____ _____
SHA Signature and Date Name of PHN Contacted by Phone & Date PHN Signature and Date

Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only. Revised 6/15

TURN FORM OVER

Students with conditions that may substantially impact school functioning (including medical or psychological conditions) may be eligible for accommodations under federal laws, specifically Section 504 of the Rehabilitation Act. Students or parents who are concerned that a diagnosed condition may interfere with the student's ability to access or participate in school activities should discuss their concerns with a school administrator.

STEP 2: EMERGENCY CALLS (To be completed by parent/guardian)

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call **Parent/Guardian** or Emergency contact(s):

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

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

I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.

Parent/Guardian Signature_____ **Date**_____

*Order form good for one school year including Summer School. Medication expiration dates: _____

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

SHA Signature and Date	Name of PHN Contacted by Phone & Date	PHN Signature and Date

Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication

SCREENING QUESTIONNAIRE FOR SEVERE ALLERGIES

Student's name: _____ Date of Birth:_____ Today's date:_____

Grade _____ School: _____Public Health Nurse's phone number: _____

Please answer the questions as completely as possible and return to the Public Health Nurse in the clinic of your child's school. **If you have any questions or concerns, or if you would rather discuss these questions by phone, please call the Nurse at the phone number above.**

1. What is your child allergic to? Please list all allergies:_____
2. What happens when your child has an allergic reaction?_____
3. When did your child have his/her first allergic reaction? _____
4. Date of most recent allergic reaction? _____ Describe what happened? _____

_____

What medication(s) was (were) given for the reaction? _____

5. Has your child had any of the following reactions?

Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Yes	☐ No
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Yes	☐ No
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Yes	☐ No
Throat	Tightening of throat, hoarseness, hacking cough	☐ Yes	☐ No
Lung	Shortness of breath, repetitive coughing, wheezing	☐ Yes	☐ No
Heart	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Yes	☐ No

6. Has your child ever been treated in the emergency room for a severe allergic reaction? ☐ **Yes** ☐ **No**
   If yes, when_____

7. Has your child ever been prescribed an Epi-Pen? ☐ **Yes** ☐ **No** Does s/he have an EpiPen now? ☐ **Yes** ☐ **No**

8. Do you have a regular doctor that you see for your child's allergy? ☐ **Yes** ☐ **No**
   If yes what is the doctor's name? _____ Phone Number_____

9. Do you have health insurance? ☐ **Yes** ☐ **No** If yes, what kind_____

Please note: For any allergy medication to be used at school, there must be a *Physician Order / Severe Allergy Action Plan* form completed <u>each</u> school year and kept in the clinic. <u>This includes EpiPens carried by students</u>. Please find form attached.

Students with conditions that may substantially impact school functioning (including medical or psychological conditions) may be eligible for accommodations under federal laws, specifically Section 504 of the Rehabilitation Act. Students or parents who are concerned that a diagnosed condition may interfere with the student's ability to access or participate in school activities should discuss their concerns with a school administrator.

I give permission for this information to be shared with teachers, administrators, and/or other school staff if it is needed for my child's care or safety at school.

_____ _____

Parent/Guardian Signature Date

CUESTIONARIO SOBRE LAS ALERGIAS SEVERAS

Nombre del estudiante:_____ Fecha de Nac:_____ Fecha de hoy:_____

Grado_____ Escuela: _____ Enfermera de Salud Pública/Teléfono: _____

Por favor conteste las preguntas de la forma más completa posible y devuelva a la Enfermera de Salud Pública en la clínica de la escuela de su hijo/a. **Si tiene preguntas o preocupaciones, o si prefiere discutir las preguntas por teléfono, por favor llame a la Enfermera al número mencionado arriba.**

1. ¿A qué es alérgico su hijo/a? Por favor escriba todas las alergias:_____
2. ¿Qué pasa cuando su hijo/a tiene una reacción alérgica?_____
3. ¿Cuándo tuvo su hijo/a su primera reacción alérgica? _____
4. Fecha de la reacción alérgica más reciente _____ Describa lo que pasó?_____

   _____
5. ¿Qué medicamento(s) le dieron para la reacción? _____
6. ¿Ha tenido su hija/o alguna de las siguientes reacciones?

Boca	Picazón, hormigueo, o inflamación de los labios, lengua, boca	☐ Sí ☐ No
Piel	Ronchas, sarpullido, inflamación de la cara ó de extremidades	☐ Sí ☐ No
Entrañas	Náusea, dolor abdominal, vómito, diarrea	☐ Sí ☐ No
Garganta	Apretazón de garganta, ronquera, tos seca	☐ Sí ☐ No
Pulmones	Dificultad respirando, tos constante, estridor	☐ Sí ☐ No
Corazón	Pulso débil, presión baja, desmayos, palidez y/o color azulado	☐ Sí ☐ No

7. ¿Ha sido su hijo/a alguna vez tratado/a en la sala de emergencia por una reacción alérgica severa? ☐ **Sí** ☐ **No**

   Si la respuesta es sí, cuando_____
8. ¿ Le han prescrito a su hijo/a alguna vez EpiPen? ☐ **Sí** ☐ **No** Tiene el/ella un EpiPen ahora? ☐ **Sí** ☐ **No**
9. ¿Tiene un médico de cabecera que ve a su hijo/a para su alergia? ☐ **Sí** ☐ **No**

Si la respuesta es sí, ¿cuál es el nombre del médico?_____Teléfono_____

9. ¿Tiene seguro de salud? ☐ **Sí** ☐ **No** Si tiene, ¿qué tipo?_____

Nota: Para cualquier medicina que se dé en la escuela, debe de haber una Orden Médica/Plan de Acción para Alergias Severas que debe ser completada <u>cada</u> año escolar y mantenida en la clínica de la escuela. <u>Esto incluye EpiPens que llevan los estudiantes consigo.</u> El formulario va adjunto.

Doy mi permiso para que ésta información sea compartida con los maestros, administradores, y/ú otros empleados si es necesario para el cuidado o seguridad de mi hijo/a en la escuela.

_____ _____

Firma del Padre/Encargado/Tutor Fecha