FREEDOM AREA SCHOOL DISTRICT	Freedom Area School District **Health Services** Amie Kazik RN, BSN, District Nurse Phone: 920-788-7944 DO Fax: 920-788-7949 ES Fax: 920-788-7956

Student Name:	**DOB:**	**Date:**
School:	**Grade:**	**Bus: _____Yes _____ No**
Co-curriculars:		

Health Condition: Food Allergy

Please List All Foods Your Student is Allergic to: _____

Student has anaphylaxis: _____ Yes _____ No

☐ **Student has an airborne allergy**

☐ **Student has an ingestion allergy**

Asthma History: _____ Yes _____ No *Note: History of asthma increases risk of anaphylaxis.*

History of anaphylaxis/allergic reaction? _____ Yes _____ No If yes, first line treatment for any subsequent reaction should be epinephrine.
If yes to above, please describe signs and symptoms during reaction: _____
Has epinephrine every been administered? _____ Yes _____No If yes, when? _____

Emergency Procedure:

1. Give appropriate medication as listed
2. If epinephrine is given, call 911: state an allergic reaction has been treated
3. Additional epinephrine may be needed. If symptoms continue, repeat epi-injector after 5-10 minutes.
4. Stay with student and monitor.
5. If self- administered, students must notify school personnel.

**Do not wait for previous symptoms noted above to appear before providing care. Subsequent exposures may look different.*

Symptoms: Give Checked Medication (To be determined by physician authorizing treatment)	**Administer Epinephrine**	
If food allergen has been ingested, but no symptoms:	Yes	No
Mouth:Itching, tingling, or swelling of lips, tongue or mouth	Yes	No
Skin: Hives, itchy rash, swelling of face or extremities	Yes	No
Gastrointestinal: Nausea, abdominal cramps, vomiting, diarrhea	Yes	No
Throat: Tightening of throat, hoarseness, hacking cough	Yes	No
Lungs: Shortness of breath, repetitive coughing, wheezing	Yes	No

Heart: Thready pulse, low blood pressure, fainting, pale, blue	Yes	No
Other:	Yes	No
If reaction is progressing (several of the above areas affected)	Yes	No

Emergency Contacts: Name Phone Relationship

1.

2.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911

For Completion by Physician: Name: Phone:

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr. Auvi-Q 0.3mg Auvi-Q 0.15mg

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

Is the student knowledgeable about their medication & need to notify school personnel if epinephrine is administered: _____ Yes _____ No

Has the student demonstrated the proper technique in administering medication: _____ Yes _____ No

Side effects:

( ) I have instructed _____ in the proper way to use their injected medication. It is my professional opinion that they should be allowed to carry and use this injected medication by him/herself.

( ) It is my professional opinion that _____ should not carry and use their injected medication by him/herself.

Physician's Signature: **Date:**

For Completion by Parent:
By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct. Medication Consent: I hereby give permission to designated trained school personnel to give medications to my student during the school day, including when away from the school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the student's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold the Freedom Area School District and FASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary. If self administration is allowed, or if no authorized staff member is available, I ask that my student be permitted self medication as authorized by the physician and myself. I understand as the parent/guardian, I am responsible to assure that backup rescue medication is available to my student after school hours and traveling to/from and during school-sponsored events.

Students health information is shared via emails, copies of health plans and/or staff meetings with grade

level teachers, coaches, bus companies, office staff and other pertinent FASD staff.

By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent's Signature: **Date:**

Procedure for administration of Epinephrine Auto Injector or Generic Epinephrine

You can give the injected through clothes or on bare skin

1. Take the epinephrine auto-injector out of its package
2. Remove the safety cap (blue end for Epinephrine auto-injector, both ends for generic epinephrine)
3. Hold the auto-injector in your fist
4. Push the end with the needle (orange or red) firmly against the side of the student's thigh, about halfway between the hip and knee until click is felt
5. Hold for 3 seconds, massage area for 10 seconds
6. Call 911
7. Place injector in sharps container or give to emergency responders

Procedure for administration of Auvi-Q Auto Injector

You can give the injected through clothes or on bare skin

1. Pull Auvi-Q up from outer case
2. Pull red safety guard down and off of Auvi-Q
3. Place black end of Auvi-Q against the middle of the outer thigh, then push firmly until you hear a click and hiss sound, and hold in place for 2 seconds
4. Call 911
5. Place the injector in sharps container or give to emergency responders