INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Parent/Guardian Checklist for Students with Allergies

District 196 Nursing Services encourages you to play an active role in helping us keep your child safe while at school. This checklist was developed to acquaint and assist you with the allergy management process.

____1. Notify the school nurse of your child's allergy and complete the **Student Allergy Information** form and submit it to the school nurse. The school nurse will periodically review the form, but feel free to update and re-submit this form as needed.

____2. **Each year,** prior to the **first day of school,** provide the following items to the school nurse as needed:

___ **Anaphylaxis Action Plan** signed by the parent/guardian and physician
(Note: If your child has asthma, an Asthma Action Plan is also recommended each year.)

___ Medications, if listed on the Anaphylaxis Action Plan
(Note: Epinephrine must have pharmacy label attached; check expiration dates!)

___ **Prior Consent to Release Private Data**

____3. If a special diet is requested, complete the **Special Diet Statement** signed by the parent/guardian and physician and meet with the Food and Nutrition Services Manager in your child's school to discuss your child's needs. Review appropriate menu item selections with your child.

____4. The school nurse shares information about your child's severe allergy on a need-to-know basis with additional school staff such as teachers, clerical staff, bus drivers and other support personnel. **It is, however, very helpful for you to also make contact with your child's teachers** before the beginning of each school year to inform them of your child's severe allergy and to answer any specific questions and address any concerns they may have.

____5. **Contact the coordinators of your child's before- and after-school, non-school-sponsored activities** such as School-Age Care (SAC), Camp Invention, etc. These activities may take place when the school nurse is not available.

Provide ongoing, age-appropriate teaching to your child regarding his/her allergy:

- Name the allergy or allergens;
- Teach your child how to read and recognize the potential allergens on food labels;
- Teach your child the steps to avoid coming into contact with the allergen(s) to which he/ she is allergic;
- Practice with your child how to tell an adult if he/she has had contact with the allergen;
- Practice with your child how to tell an adult if he/she has any symptoms, and
- Teach your child how to self administer prescribed Epinephrine (only with physician's authorization).

Additional information regarding food allergies may be found on the District 196 website www.district196.org at Student Services/Health Services/Allergies.

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number **506.2.3P** Adopted **September 1998** Revised **July 2012**

Title **Student Allergy Information**

Student name _____ Date of birth _____

Parent/guardian _____ Today's date _____

Home phone _____ Work _____ Cell _____

Primary healthcare provider _____ Phone _____

Allergist _____ Phone _____

1. **Does your child have an allergy diagnosis from a healthcare provider?** □ No □ Yes
2. **Does your child have a history of asthma?** □ No □ Yes
3. **History and Current Status**

What is your child allergic to?

□ Peanuts □ Fish
□ Tree nuts (walnuts, pecans, etc.) □ Shellfish
□ Milk □ Insect stings
□ Eggs □ Latex
□ Wheat □ Chemicals _____
□ Soy □ Vapors _____
□ Other _____

Age of child when allergy first discovered _____

How many times has your child had a reaction?

□ never □ once □ more than once, explain:

_____

Explain past allergic reaction(s) _____

Symptoms _____

Are the food allergy reactions:

□ staying the same □ getting better □ becoming worse

4. **Trigger and Symptoms**

What are the early signs and symptoms of your child's allergic reaction? (Be specific; include things your child might say.)

_____

_____

How does your child communicate his/her symptoms? _____

How quickly do symptoms appear after exposure of allergen? secs. _____ mins. _____ hrs. ____ days _____

Please check the symptoms that your child has experienced in the past:

Skin: □ Hives □ Itching □ Rash □ Flushing □ Swelling (face, arms, hands, legs)

Mouth: □ Itching □ Swelling (lips, tongue, mouth)

Abdominal: □ Nausea □ Cramps □ Vomiting □ Diarrhea

Throat: □ Itching □ Tightness □ Difficulty swallowing □ Hoarseness □ Cough

Lungs: □ Shortness of breath □ Repetitive cough □ Wheezing

Heart: □ Weak pulse □ Loss of consciousness

5. **Treatment**

How have past reactions been treated? _____

How effective was the child's response to treatment? _____

Was there an emergency room visit? □ No □ Yes, explain _____

Was the student admitted to the hospital? □ No □ Yes, explain _____

What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

_____

Has your healthcare provider given your child a prescription for medication? □ No □ Yes

Have you used the treatment or medication? □ No □ Yes

Please describe any side effects or problems your child has had in using the suggested treatment: _____

_____

6. Self Care

Is your child able to monitor and prevent their own exposures? ☐ No ☐ Yes

Does your child:

Know what foods to avoid? ☐ No ☐ Yes

Ask about food ingredients? ☐ No ☐ Yes

Read and understand food labels? ☐ No ☐ Yes

Tell an adult immediately after an exposure? ☐ No ☐ Yes

Wear a medical alert bracelet, necklace, watchband? ☐ No ☐ Yes

Tell peers and adults about the allergy? ☐ No ☐ Yes

Firmly refuse a problem food? ☐ No ☐ Yes

Does your child know how to use emergency medication? ☐ No ☐ Yes _____

Has your child ever administered their own emergency medication? ☐ No ☐ Yes _____

7. Family/Home

Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes

Do you feel that your child needs assistance in coping with his/her allergy? ☐ No ☐ Yes

How do you feel your family as a whole is coping with your child's allergy? _____

_____

8. General Health

How is your child's general health other than having an allergy? _____

Does your child have other health conditions? _____

Hospitalizations? _____

Please add anything else you would like the school to know about your child's health: _____

_____

9. Notes: _____

_____

_____

This procedure will be reviewed and revised when deemed appropriate by the school nurse (LSN) or parent/guardian.

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Adapted with permission – Washington State Guidelines for Anaphylaxis and National Association of School Nurses

Asthma Action Plan

DATE: ____ /____ /____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: ____ /____ /____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE DOING WELL GO!

You have ALL of these:
- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

Peak Flow is between: ____ **and** ____
80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

You have ANY of these:
- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

Peak Flow is between: ____ **and** ____
50-79% of personal best

Step 1: Keep taking GREEN ZONE medicines and **ADD** quick-relief medicine:
_____ *puffs or 1 nebulizer treatment of* _____
Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the GREEN ZONE, take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **more than 6 hours**, or your symptoms are **getting worse**, follow RED ZONE instructions.

RED ZONE EMERGENCY GET HELP NOW!

You have ANY of these:
- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: ____ **and** ____
Below 50% of personal best

Step 1: Take your quick-relief medicine NOW:

MEDICINE	HOW MUCH

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider NOW
AND
Go to the emergency room OR CALL 911 immediately.

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: ____ /____ /____ MD/NP/PA SIGNATURE _____

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable).*

DATE: ____ /____ /____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

Anaphylaxis Action Plan

DO NOT HESITATE to give Epinephrine.
Anaphylaxis is a serious and potentially life threatening allergic reaction that is rapid in onset.

Name _____ Date of Birth _____

Allergic to _____
(Please indicate specific food, animals, insects, or substances)

☐ Yes ☐ No History of Asthma

What Dose of Epinephrine (in milligrams)?
- ☐ EpiPen Jr. (0.15mg dose for up to 55 pounds)
- ☐ EpiPen (0.3mg dose for over 55 pounds)
- ☐ May carry and self-administer medication

Antihistamine Type
- ☐ Diphenhydramine
- ☐ Other _____
- ☐ May carry and self-administer medication

What Dose of Antihistamine (in milligrams)?
- ☐ 12.5mg ☐ 50mg
- ☐ 25mg ☐ Other dosage: _____
- ☐ May carry and self-administer medication

Mild Symptoms

Mild symptoms only:
Mouth - Itchy mouth
Skin - A few hives around mouth/face, mild itch
Stomach - Mild nausea/discomfort

→
1. Give Antihistamine
2. Stay with student; alert health care professionals and parent/guardian
3. If symptoms progress (see below) USE EPINEPHRINE
4. Begin monitoring (as specified below)

Extremely Reactive or Severe Symptoms

→
1. Inject Epinephrine immediately
2. Call 911
3. Begin monitoring (as specified below)
4. Give additional medications:
   - Antihistamine
   - Inhaler if asthma

If Checked:

☐ Give Epinephrine immediately for a **bee sting or exposure to other documented allergen**

☐ Give Epinephrine immediately if food was likely or definitely eaten.

One or more of the following severe symptoms after suspected or known ingestion:

Lung - Short of breath, repetitive cough, wheezing
Heart - Faint, weak pulse, dizzy, confused
Throat - Tight, hoarse, trouble breathing/swallowing
Mouth - Obstructive swelling (tongue and/or lips)
Skin - Pale, blue, many hives over body, itchy rashes, swelling (eyes, lips)
Stomach - Nausea, vomiting, severe cramps, diarrhea

Monitoring:

- Second dose of Epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.
- **Stay with student, call 911 and alert health care professionals and parent/guardian.**
- Tell emergency personnel Epinephrine was given.
- Note time when Epinephrine was administered.
- For a severe reaction, consider keeping person lying on back with legs raised.
- Treat student even if parents cannot be reached.

Other situations: _____

Physician Signature _____ Phone _____ Date _____

Physician Name (Printed) _____ Clinic Name _____

Parent/Guardian Signature _____ Phone _____ Date _____

Other emergency contact:

Name/Relationship _____ Phone _____

Special Diet Request

Student's Name/grade/teacher_____

Dietary Modifications to be made, including objections to a specific food:_____

_____

Lactose Intolerance__Y/N__

No milk to drink____Y/N___

Other foods with lactose to exclude:_____

Food or Ingredient Intolerance:__Y/N__ food/s intolerant to:_____

Reaction to foods:_____

Food Allergy: __Y/N__ food/s allergic to:_____

Reaction to allergen:_____

EPI PEN:__Y/N__ Location of EPI PEN: Nurse or Self carry, where kept?_____

Is student to sit at allergen free table? ____Y/N____

If allergen is nuts, is cross contaminated food OK? __Y/N__

Foods to be omitted:_____

Foods to be substituted:_____

First Baptist cannot guarantee that the facility or dining area will be allergen free. First Baptist is not required to provide food substitutions, but every effort will be made to accommodate your request.

Parent or guardian signature:_____

Thank you so much. If you have any questions please contact Beth Reilly, RN, Licensed School Nurse or Mrs. McCannon.