Annual Student Information – Allergy

Student Information: Teacher _____

Student's Name _____ Date of Birth _____ Grade _____

Mother's Name _____ Home # _____

Work # _____ Other # _____

Father's Name _____ Home # _____

Work # _____ Other # _____

Emergency Contact if Parent/Guardian unavailable:

Name _____ Relationship _____ Daytime Phone # _____

Name _____ Relationship _____ Daytime Phone # _____

In case of an emergency and I cannot be reached, I authorize school personnel to contact:

Physician _____ Clinic _____ Phone # _____

or transport by ambulance to _____ (Hospital)

Health History

What is your child allergic to? _____

- **<u>If your child has a food allergy</u>, please also complete the attached form.**

Age at onset of severe allergy _____ Date of last severe allergic reaction _____

When was the last time that your child was treated with epinephrine? _____

How many times has your child been treated with epinephrine? _____

Does your child also have asthma? □ Yes □ No

Does your child receive allergy shots? □ Yes ☞ for which allergens? _____ □ No

How soon after contact does your child react? _____ minutes, _____ hours, _____ days

What are the early-warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction? _____

Please circle any and all symptoms your child has had and check the medication required:

<u>Symptoms:</u>	**<u>Check Medication for each symptom:</u>** <u>To be determined with the physician authorizing treatment.</u> <u>Section not needed if you attach an Anaphylaxis Action Plan</u>
If a food allergen has been ingested, but *no symptoms*:	□Epinephrine □Antihistamine □Nothing
Mouth Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine □Antihistamine □Nothing
Skin Hives, itchy rash, swelling of the face or extremities	□Epinephrine □Antihistamine □Nothing
Gut Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine □Antihistamine □Nothing
Throat ✝Tightening of throat, hoarseness, hacking cough	□Epinephrine □Antihistamine □Nothing
Lung ✝ Shortness of breath, repetitive coughing, wheezing	□Epinephrine □Antihistamine □Nothing
Heart ✝Thready pulse, low blood pressure, fainting, pale, blueness	□Epinephrine □Antihistamine □Nothing
Other_____	□Epinephrine □Antihistamine □Nothing
◎◎If reaction is progressing (several of the above areas affected), give:	□Epinephrine □Antihistamine □Nothing

The severity of symptoms can quickly change. **✝Potentially life-threatening.**

(Continued on other side)

Medication prescribed for management of your child's allergic reaction

Epinephrine: inject intramuscularly (circle one) EpiPen®, EpiPen® Jr., Twinject™ 0.3 mg, Twinject™ 0.15 mg

- **Please provide at least 2 EpiPens® or EpiPen® Jr.s to school**

Is your child able to correctly administer his/her own Epi-pen? □ Yes □ No

Antihistamine:

give_____

medication/dose/route

Other:

give_____

Parents must provide all medications for their children. Written parent and physician authorization is required for students to take long-term prescription medications at school. Older students, instructed in the proper use and administration of their Epi-pen by their parents and/or physician, may carry and self-administer their Epi-pen with written parent and physician authorization (by checking yes to "This student has been trained and is capable to carry and self-administer this medication" on the Medication Authorization Form). I recommend that a back-up Epi-pen be kept in the Health Office. **It is the parent's responsibility to contact KCS health office and teacher if their child has a medical concern and/or needs medication during these times.**

Listed below is the procedure school personnel will follow in the event of a severe allergic reaction in school:

1. Depending on the symptom and the medication checked above:

a. Medication will be administered according to physician orders and a parent/guardian will be notified
b. If an Epi-pen is required and the student is able to self- administer it, he/she will be assisted.
c. 911 will be called.
d. The parent/guardian will be notified.
e. The student will be monitored until the ambulance arrives.

Other _____

Concerns and/or comments which will help me plan and care for your child during the school day:

_____

Does your child understand his/her allergy, the allergen to avoid, symptoms of his/her allergic reaction and management of his/her allergic reaction? □ Yes □ No

If not, what additional teaching is needed?

_____

Would you like a phone call from or an appointment with the School Nurse? □ Yes □ No

Feel free to call the health clerk with questions:

Nurse Name: Amy Jorgenson, CMA – Health Clerk Office phone #: 763-428-1890 or email ajorgenson@KCSMN.org

For your child's safety, can this information be shared with school personnel working with your child? □ Yes □ No

I give the Kaleidoscope Charter School permission to contact the above named doctor regarding my child's allergy should the need arise. I have reviewed and agree with the nursing management plan for my child's allergic reaction outlined above. I will notify the health clerk of any changes in management of my child's allergic reaction.

Parent Signature _____ Date _____