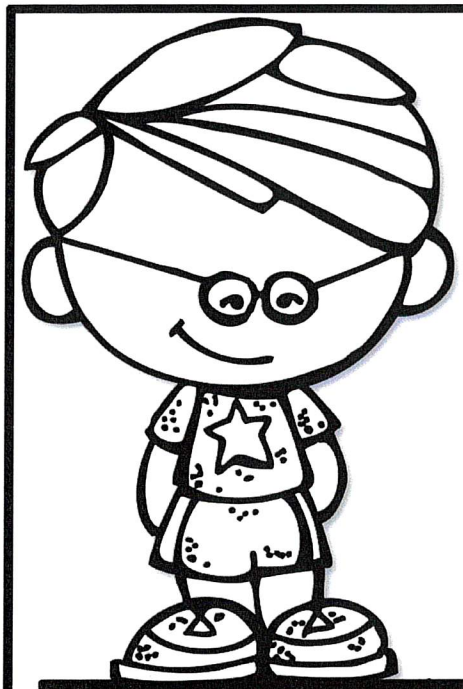


FOOD ALLERGIES & ANAPHYLAXIS CHECKLIST

Students with food allergies can stay safe at school, it takes organization, preparation, and education. Work with the school nurse to create a comprehensive Food Allergy Management and Prevention Plan for your child. This plan will detail how the school will accommodate your child's food allergy. Every school year new allergy forms need to be completed. **Refer to the checklist below for the forms to turn into the school on or before the first day of school.** Copies of these forms are included in this packet. All allergy information can be found on the school website www.saseasschool.org on the school nurse page.

Things To Do

- ✓ Contact the school nurse powderlya@saseas.org before school starts with allergy information of your child.
- ✓ Request a meeting with the school nurse if necessary to discuss allergy and plan of care.
- ✓ Compete and return all required forms ll forms and medications need to be turned into the school nurse by the first day of school.
- ✓ Be involved.

Items To Provide To School Nurse

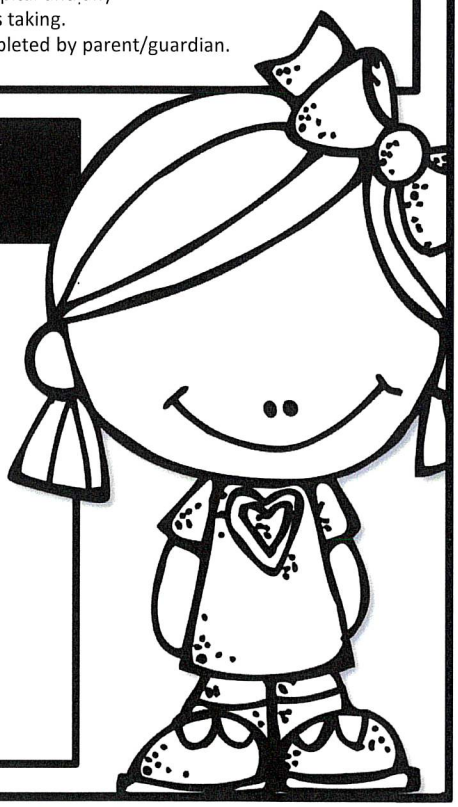
- ✓ Diagnosis from medical provider-if anaphylaxis is suspected, this needs to be documented on the form from the medical provider.
- ✓ Medication authorization forms-with your medical provider's signature and parent/guardian section completed. Each medication must be on a separate form.
- ✓ FARE-Food Allergy & Anaphylaxis Emergency Care Plan-completed and signed by medical provider and parent/guardian. This form tells caregivers what to do in case of an allergic reaction. It describes your child's symptoms and doses of medications.
- ✓ All medications need to have a current pharmacy label and in the original container. Be sure to note the expiration date so a replacement can be obtained.
- ✓ Special Dietary Needs Accommodations Form if your child will be eating meals provided by the school.
- ✓ Emergency contact information. Please include all contact information, phone numbers, preferred hospital and any current medications the child is taking.
- ✓ Food allergy history form-completed by parent/guardian.

Tips & Suggestions

- ✓ Please consider volunteering to be a room parent and/or field trip chaperone.
- ✓ Discuss classroom parties and celebration with teacher.
- ✓ As you discover new information in your child's treatment protocol please share it with the school nurse.
- ✓ Review the do's and don'ts of food safety and emergency plans with your child on a regular basis (especially avoiding food sharing).
- ✓ Pay close attention to special events happening at school. Read the newsletter carefully, this is where most of this information is shared.
- ✓ Make sure your contact information you provided to the school is correct. Your child will be safer if you can be reached easily. Make sure your cell phone is on and working.

RESOURCES

The Food Allergy Network for Kids	www.fankids.org
Food Allergy Awareness, Support and Training	www.faastcincy.org
The Food Allergy Anaphylaxis Network	www.foodakkergy.org
Food Allergy Research & Education	www.foodallergy.org



ALLERGY HEALTH HISTORY

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 a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?
- ❑ Peanuts
- ❑ Eggs
- ❑ Milk
- ❑ Latex
- ❑ Soy
- ❑ Other: _____
- ❑ Insect Stings
- ❑ Fish/Shellfish
- ❑ Chemicals _____
- ❑ Vapors _____
- ❑ Tree Nuts (walnuts, pecans, etc.)

b. Age of student when allergy first discovered: _____
c. How many times has student had a reaction?
❑ Never ❑ Once ❑ More than once, explain:
_____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ❑ Same ❑Better ❑ Worse

3. Trigger and Symptoms

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

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. 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	❑ Hoarseness	❑ Cough	
Lungs:	❑ Shortness of breath		❑ Repetitive Cough		❑ Wheezing
Heart:	❑ Weak pulse	❑ Loss of consciousness			

4. Treatment

a. How have past reactions been treated? _____
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____
e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
_____
f. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
g. Have you used the treatment or medication? ❑ No ❑ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

Parent/Guardian Completes

(over)

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ❑ No ❑ Yes
b. Does your student:
   1. Know what foods to avoid ❑ No ❑ Yes
   2. Ask about food ingredients ❑ No ❑ Yes
   3. Read and understands food labels ❑ No ❑ Yes
   4. Tell an adult immediately after an exposure ❑ No ❑ Yes
   5. Wear a medical alert bracelet, necklace, watchband ❑ No ❑ Yes
   6. Tell peers and adults about the allergy ❑ No ❑ Yes
   7. Firmly refuses a problem food ❑ No ❑ Yes
c. Does your child know how to use emergency medication? ❑ No ❑ Yes _____
d. Has your child ever administered their own emergency medication? ❑ No ❑ Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? _____
b. Does your child carry epinephrine in the event of a reaction? ❑ No ❑ Yes
c. Has your child ever needed to administer that epinephrine? ❑ No ❑ Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy? _____

7. General Health

a. How is your child's general health other than having a food allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of asthma? ❑ No ❑ Yes
   If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes
e. Please add anything else you would like the school to know about your child's health: _____
   _____

8. Notes:

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by R.N.: _____ **Date:** _____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

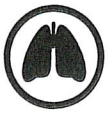
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

Medical Provider Completes

ST. ANDREW-ST. ELIZABETH ANN SETON SCHOOL

PRESCRIPTION MEDICATION AUTHORIZATION School Year _____-_____

STUDENT INFORMATION

Student's Name: _____ **Grade:** _____

Date of Birth: ____/_____/_____ **Age:** _____

Drug Allergies: _____ **Weight:** _____pounds

PRESCRIBER AUTHORIZATION (To be completed by a licensed health care provider)

Medication Name: _____ **Dosage:** _____

Frequency/Times to Be Given: _____ **Route:** _____

Start Date: _____/_____/_____ **Stop Date:** _____/_____/_____

Reason for Taking Medication: _____

Potential Side Effects: _____

Special Instructions for administration: _____

Special Instructions for storage: _____

Is this medication a controlled substance: **Yes**_____ **No**_____

Printed Name of Licensed Provider: _____

Health Provider Phone Number: (_____)-_____-_____

Health Provider Signature: _____ **Date:** ____/_____/_____

PARENT AUTHORIZATION

I authorize the school nurse, principal or delegated personnel to administer the above medication prescribed by his/her healthcare provider during the school day. I assume responsibility for the delivery of my child's medication and the completed medication authorization form to the school. I will notify the school if the medication, dosage or physician changes. I understand that a new medication authorization will be necessary if any changes are made to the medication or dosage.

Parent/Guardian Name: _____ **Phone:** (_____)_____-_____

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Before your child can take any medication at school, you must provide the school with a written request from the parent/guardian and a written statement from the health care provider. The statement must include the following:

1. The name of the medication and dosage to be administered
2. The time(s) the medication is to be administered
3. The date the administering medication is to start and end
4. Any potential side effects or severe adverse reactions that should be reported
5. Special instructions for administration and storage of the medication
6. THE PARENT MUST BRING THE MEDICATION TO THE SCHOOL OFFICE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED (Most pharmacies will gladly give you a smaller duplicate prescription bottle for you to put in the necessary doses needed at school)

St. Elizabeth Ann Seton Campus
5900 Buckwheat Road
Milford, Ohio 45150
513-575-0093

St. Andrew Campus
555 Main Street
Milford, Ohio 45150
513-831-5277

ST. ANDREW-ST. ELIZABETH ANN SETON SCHOOL

PRESCRIPTION MEDICATION AUTHORIZATION School Year _____-_____

STUDENT INFORMATION

Student's Name: _____ **Grade:** _____

Date of Birth: ____/_____/_____ **Age:** _____

Drug Allergies: _____ **Weight:** _____**pounds**

PRESCRIBER AUTHORIZATION (To be completed by a licensed health care provider)

Medication Name: _____ **Dosage:** _____

Frequency/Times to Be Given: _____ **Route:** _____

Start Date: _____/_____/_____ **Stop Date:** _____/_____/_____

Reason for Taking Medication: _____

Potential Side Effects: _____

Special Instructions for administration: _____

Special Instructions for storage: _____

Is this medication a controlled substance: **Yes**_____ **No**_____

Printed Name of Licensed Provider: _____

Health Provider Phone Number: (_____)-_____-_____

Health Provider Signature: _____ **Date:** ____/_____/_____

PARENT AUTHORIZATION

I authorize the school nurse, principal or delegated personnel to administer the above medication prescribed by his/her healthcare provider during the school day. I assume responsibility for the delivery of my child's medication and the completed medication authorization form to the school. I will notify the school if the medication, dosage or physician changes. I understand that a new medication authorization will be necessary if any changes are made to the medication or dosage.

Parent/Guardian Name: _____ **Phone:** (_____)_____-_____

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Before your child can take any medication at school, you must provide the school with a written request from the parent/guardian and a written statement from the health care provider. The statement must include the following:

1. The name of the medication and dosage to be administered
2. The time(s) the medication is to be administered
3. The date the administering medication is to start and end
4. Any potential side effects or severe adverse reactions that should be reported
5. Special instructions for administration and storage of the medication
6. THE PARENT MUST BRING THE MEDICATION TO THE SCHOOL OFFICE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED (Most pharmacies will gladly give you a smaller duplicate prescription bottle for you to put in the necessary doses needed at school)

St. Elizabeth Ann Seton Campus
5900 Buckwheat Road
Milford, Ohio 45150
513-575-0093

St. Andrew Campus
555 Main Street
Milford, Ohio 45150
513-831-5277

ST. ANDREW-ST. ELIZABETH ANN SETON SCHOOL

PRESCRIPTION MEDICATION AUTHORIZATION School Year _____-_____

STUDENT INFORMATION

Student's Name: _____ **Grade:** _____

Date of Birth: ____/_____/_____ **Age:** _____

Drug Allergies: _____ **Weight:** _____**pounds**

PRESCRIBER AUTHORIZATION (To be completed by a licensed health care provider)

Medication Name: _____ **Dosage:** _____

Frequency/Times to Be Given: _____ **Route:** _____

Start Date: _____/_____/_____ **Stop Date:** _____/_____/_____

Reason for Taking Medication: _____

Potential Side Effects: _____

Special Instructions for administration: _____

Special Instructions for storage: _____

Is this medication a controlled substance: **Yes**_____ **No**_____

Printed Name of Licensed Provider: _____

Health Provider Phone Number: (_____)-_____-_____

Health Provider Signature: _____ **Date:** ____/_____/_____

PARENT AUTHORIZATION

I authorize the school nurse, principal or delegated personnel to administer the above medication prescribed by his/her healthcare provider during the school day. I assume responsibility for the delivery of my child's medication and the completed medication authorization form to the school. I will notify the school if the medication, dosage or physician changes. I understand that a new medication authorization will be necessary if any changes are made to the medication or dosage.

Parent/Guardian Name: _____ **Phone:** (_____)_____-_____

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Before your child can take any medication at school, you must provide the school with a written request from the parent/guardian and a written statement from the health care provider. The statement must include the following:

1. The name of the medication and dosage to be administered
2. The time(s) the medication is to be administered
3. The date the administering medication is to start and end
4. Any potential side effects or severe adverse reactions that should be reported
5. Special instructions for administration and storage of the medication
6. THE PARENT MUST BRING THE MEDICATION TO THE SCHOOL OFFICE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED (Most pharmacies will gladly give you a smaller duplicate prescription bottle for you to put in the necessary doses needed at school)

St. Elizabeth Ann Seton Campus
5900 Buckwheat Road
Milford, Ohio 45150
513-575-0093

St. Andrew Campus
555 Main Street
Milford, Ohio 45150
513-831-5277