Alamogordo Public Schools
Allergy and Anaphylaxis Form

School_____

Name _____ Grade___ Allergy(s) _____

Parent Name (s)_____ Phone #'s_____ _____

☐ Life-Threatening:

- 504 eligibility review
- **Must Have Dr. Orders below**
- Plan for transportation concerns
- Field trip and classroom parties
- Provide cafeteria staff with Dr. orders and food recommendations

☐ Non Life-threatening:

- If it is a food that can easily be avoided, (ie, strawberries, bananas) send notification to the cafeteria staff. No other requirements are needed.
- If it is a food that is hidden in recipes (ie, eggs, gluten) and modifications need to be made by the cafeteria staff, have the **Dr. orders and recommendations** below signed by provider

☐ Intolerance:

- Student may refuse the item (ie. milk)
- Parent may provide an alternative and cafeteria staff will give the alternative to the child at mealtime. (ie. soymilk, almond milk)

Healthcare Provider Orders for Emergency Medications:

Foods to be avoided _____

_____

Recommendations for substitutions (requires healthcare provider signature) _____

_____

Medication

☐ Epinephrine (0.15mg) inject intramuscularly ☐ Epinephrine (0.3mg) inject intramuscularly

Circle One: Epi Pen Auvi Q Andrenaclick

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur

Benadryl/Diphenhydramine Dose: _____ Route: PO Frequency _____	Other: _____ Dose _____ Route: _____ Frequency: _____	NOTE: If nurse is not available , the above treatment plan may be provided by trained school Personnel for any Anaphylaxis symptoms

Treatment

For any of the following Symptoms follow Protocol	**Protocol**
Severe Symptoms **Lungs:** Difficulty breathing, wheezing, coughing **Heart:** Dizzy, faint, confused, pale, blue, weak pulse **Throat:** Tight, horse, trouble swallowing, drooling **Mouth:** Significant swelling of tongue, lips **Skin:** Many hives over body, widespread redness over body **Gut:** Nausea, vomiting, diarrhea, cramping **Other:** Feeling something bad is about to happen, anxiety, _____	1. **Inject Epinephrine Immediately** (see back of form for further instructions) 2. **Call 911**
Mild symptoms **Mouth:** Itchy mouth, lips, tongue, or throat **Skin:** Itchy Skin **Nose:** Itchy/runny nose **Gut:** Mild nausea/discomfort **Other:** _____	1. Give Antihistamine as directed (Benadryl/Diphenhydramine) 2. If symptoms worsen, GO TO EPINEPHRINE PROTOCOL as ordered

☐ **Please allow student to carry emergency meds. The child has been trained on proper use of medication.**

_____ _____
Signature of Healthcare Provider Date

Phone Number _____

_____ _____
Signature of Parent Date

_____ _____
Signature of Nurse Date

Alamogordo Public Schools
Health Services

Parent Questionnaire for Food Allergies (Elementary Schools)

Child'sName_____Allergy_____

Our goal is to keep your child safe and provide students as much independence as is possible in the least restrictive environment, while assisting you in preparing your child with lifelong skills.
Please answer the questions below to help us keep your child safe in the school.

Symptoms my child experiences are: (Check all that Apply)

- ☐ **Mouth:** Itching, tingling, or swelling of lips, tongue, mouth
- ☐ **Skin:** Hives, itchy rash, swelling of the face or extremities
- ☐ **Throat:** Tightening of throat, hoarseness, hacking cough
- ☐ **Lung**: Shortness of breath, repetitive coughing, wheezing
- ☐ **Heart:** Weak or thready pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other:** _____

My child takes the following Medications when above symptoms occur: :*

Epi-Pen®____ _ Epinephrine Auto-Injecor_____ Benadryl_____ Other___

*The Safest environment is to have the above in the Health Office, even if your child also carries it with them. Please call your physician for appropriate orders.

Areas which need to be Addressed for a Safe Environment:

- Can your child identify what foods to avoid? Yes____ No____
- Will he/she be eating school breakfast? Yes____ No____
- Will he/she be eating school lunch ? Yes____ No____
- Will your child be carrying above meds with them? Yes____No____
- Does your child understand when to get help if symptoms occur? Yes____ No____
- May we distribute/post a picture of your child? Yes____No____
- Has he/she ever gone to the ER/Hospital due to allergic reaction? Yes____ No____
- Would you like to meet with school staff regarding these allergy(s) Yes____ No____

Comments_____

Please return this form to the school nurse as soon as possible. It is the responsibility of the parent to inform the health office if any changes occur to above questions.

Parent/Guardian Signature_____Date_____

Alamogordo Public Schools
Health Services

Parent Questionnaire for Food Allergies (Secondary Schools)

Child's Name_____Allergy_____

Our goal is to keep your child safe and provide students as much independence as is possible in the least restrictive environment, while assisting you in preparing your child with lifelong skills.
Please answer the questions below to help us keep your child safe in the school.

Symptoms my child experiences are: (Check all that Apply)

- ☐ **Mouth**: Itching, tingling, or swelling of lips, tongue, mouth
- ☐ **Skin**: Hives, itchy rash, swelling of the face or extremities
- ☐ **Throat:** Tightening of throat, hoarseness, hacking cough
- ☐ **Lung**: Shortness of breath, repetitive coughing, wheezing
- ☐ **Heart:** Weak or thready pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other**: _____

My child takes the following Medications when above symptoms occur: :*

Epi-Pen®____ _ Epinephrine Auto-injector _____ Benadryl_____ Other __

*The Safest environment is to have the above in the Health Office, even if your child also carries it with them. Please call your physician for appropriate orders.

Areas which need to be Addressed for a Safe Environment:

- Can your child identify what foods to avoid without assistance? Yes____ No____
  If no, please explain_____
- Does your child ride a bus to/from school? Yes____ No____
- Will your child be carrying above meds with them? Yes____ No____
- Does your child understand when to get help if symptoms occur? Yes____ No____
- Is your child scheduled to take any cooking classes this year? Yes____ No____
- Will your child be involved in any extracurricular activities this year Yes___ No____
  If so, what activities_____
  Parents are responsible for notifying coaches/trainer
- May we distribute/post your child's picture Yes____No____
- Has he/she ever gone to the ER/Hospital due to allergic reaction? Yes____ No____
- Would you like to meet with school staff regarding these allergies? Yes____ No____

Comments_____

Please return this form to the school nurse as soon as possible. It is the responsibility of the parent to inform the health office if any changes occur to above questions.

Parent/Guardian Signature_____Date_____

Alamogordo Public Schools
Health Services

CONSENT FOR STUDENT TO CARRY EPI-PEN

Date: _____

It is medically necessary for my child, _____, to carry his/her own epi-pen and dispense the dose. She/he has been instructed by the physician and understands the proper use and instruction for dosage and frequency.

I understand that this is an unusual circumstance and deviates from the usual policies of Alamogordo Public School. I also acknowledge that it will not be possible for school staff to monitor or document doses, frequency, technique or responses of the child to the medication. I also realize that the school staff cannot control the possibility that accidents involving other students can occur with unsecured medications. My child is to keep his/her epi-pen at all times, including transport to and from school.

If the epi-pen is used, please call for the nurse immediately.

_____
Parent/Guardian

Date: _____

School: _____