



# Health Services

1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

## Allergic Reaction Parent-Physician Information 2018-19

### PARENT INFORMATION

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Phone Contact #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Phone Contact #2: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_ Allergy Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital Preference  Lutheran ( W. Jefferson)  Lutheran (Dupont)  Parkview (North)  Parkview (Randallia)  Saint Joseph

#### Identify the things that may trigger allergic symptoms in your child - Check all that apply

- Animals  Bee/Insect  Latex  Medication  Food allergy (list foods) \_\_\_\_\_
- Seasonal  Pollens  Other: \_\_\_\_\_

#### Symptoms -Check all that apply

- Hives, itchy rash  Localized swelling  Swelling of face  Itching & swelling of the lips, tongue, or mouth  Tightness in the throat, hoarseness
- Nausea, abdominal cramps, vomiting, diarrhea  Shortness of breath, repetitive coughing, wheezing  Rapid heart rate  Passing out  Other \_\_\_\_\_

#### Other Information –Check all that apply

- My child has an EpiPen prescribed  My child knows how to properly use an EpiPen  My child has an inhaler prescribed  My child eats school lunch

**Note: 911 will be called immediately when an EpiPen is administered at school. If school nurse is not available EpiPen may be administered by trained unlicensed staff in the school setting.**

#### Emergency Medications – What medication/s does your child take for emergency allergic symptoms?

Medication Name	Amount	Given for what symptoms
1.		
2.		
3.		

#### Outside Activity and Field Trips. The following medications should accompany my child when participating in outside activity and field trips. Include DIRECTIONS

1. \_\_\_\_\_ 2. \_\_\_\_\_

I agree that this information (plan) may be shared with the appropriate staff members, who work with the student, on a need to know basis. I hereby release Fort Wayne Community School District and any of its agents, employees, administrators, from any liability for any injury or harm which is suffered by my child as a result of our District's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's allergy treatment plan for school. I agree to keep the school nurse updated in writing about my child's health, and contact the school nurse in writing if any changes are made in the plan.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Allergic Reaction Parent and Physician Information 2018-19

### PHYSICIAN INFORMATION *This section is only to be filled out by the health care provider and is only necessary for the special circumstances listed below.*

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

This student has an allergy to \_\_\_\_\_ and will require the following modifications to the school day to ensure his/her safety and wellbeing.

#### Student will need emergency medications for the following symptoms:

If student is stung or a food allergen has been ingested, but NO SYMPTOMS	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Mouth:</b> itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Gut:</b> nausea, abdominal cramps vomiting, diarrhea	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Throat:</b> tightening of throat, hoarseness hacking cough	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Lung:</b> shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
<b>Heart:</b> weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
Other:	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler
If reaction is progressing (several of the above areas affected) give:	<input type="checkbox"/>	Epinephrine	<input type="checkbox"/>	Diphenhydramine	<input type="checkbox"/>	Rescue Inhaler

#### DOSAGE

**Epinephrine:** Inject intramuscularly (circle one)      EpiPen      EpiPen Jr.

**Antihistamine:** Give: \_\_\_\_\_  
(Diphenhydramine)      Medication:      Amount:      Route:

**Rescue Inhaler:** Give \_\_\_\_\_  
                                 Medication      Number of puffs

- Student's allergy is potentially life threatening and needs a modification to school lunch       Student needs to eat in separate dining area
- Student medication may be secured in the school clinic.       Student MUST carry own emergency medication on their person at all times.
- Other modification needed \_\_\_\_\_

**Note: 911 will be called immediately when an EpiPen is administered at school. If school nurse is not available EpiPen may be administered by trained unlicensed staff in the school setting.**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_