Severe Allergy Action Plan

Castlemont Community Transformation Schools

Please Attach to Authorization for Medication Form

Student's Name: _____ Date of Birth: _____

School: ☐ Castlemont Primary Academy ☐ Castlemont Junior Academy Grade: _____ Teacher: _____ Room: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Healthcare Provider Name: _____ Healthcare Provider Phone: _____

TO BE COMPLETED BY A LICENSED PHYSICIAN

Allergy to _____ Asthma: ☐ Yes (higher risk for severe reaction) ☐ No

Extremely reactive to the following foods _____

Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten ☐ Yes ☐ No

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble /swallowing, obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: hives itchy rashes, swelling (e.g. eyes, lips)
- GUT: Vomiting, diarrhea, cramping pain

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1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medication:*
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).* ***USE EPINEPHRINE!*

MILD SYMPTOMS ONLY:
- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

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1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see below)

MONITORING

Stay with student; alert healthcare professional and parent. Tell paramedic epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first symptoms persist or recur. For a severe reaction, consider keeping student on back with legs raised. Treat student even if parents cannot be reached.

Health Care Provider

My signature provides authorization for the above written order. I understand that all procedures will be implemented in accordance with state laws and regulations.

Student carry and self-administer epinephrine auto injector: ☐ Yes ☐ No **Location of epinephrine auto injector**: _____

Print Provider Name/Credentials: _____ Signature _____ Date _____

Parent Consent for Authorization and Management of Anaphylaxis in School Setting

I request that anaphylaxis treatment be administered to my child in accordance with state law and regulations. I understand that the medication must have a pharmacy label with the name of the student and health care provider. I give permission for school staff to communicate with the health care provider on matters related to this Allergy Action Plan. I will:

1. Provide the necessary supplies and equipment;
2. Notify the school if there is a change in my child's health status or attending authorized healthcare provider; and
3. Notify the school immediately and provide new written consent/authorization for any changes in the above authorization.

My child carry and self-administer epinephrine auto injector: ☐ Yes ☐ No

Print Parent Name: _____ Signature _____ Date _____

July 2015 Source: Oakland Unified School District

Medical Statement to Request Special Meals

Castlemont Community Transformation Schools

******To be completed by physician if student has a food allergy******

Student's Name: _____ Date of Birth: _____

School: ☐ Castlemont Primary Academy ☐ Castlemont Junior Academy Grade: _____ Teacher: _____ Room: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Healthcare Provider Name: _____ Healthcare Provider Phone: _____

Medical Condition Requiring Special Accommodations:

Severe Allergy to:_____

Provide a Brief Description of Participant's Major Life Activity Affected by the Medical Condition:

Life threatening food allergy (anaphylaxis) inhibits eating.

Diet Prescription and/or Accommodation: (Please describe in detail to ensure proper implementation)

Prohibit student's ingestion of/exposure to: _____

_____

_____

Foods to be Omitted and Substitutions: (Please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information)

⇒ **Foods to be omitted**

_____

_____

_____

⇒ **Suggested substitutions**

_____

_____

_____

Health Care Provider

My signature provides authorization for the above written order. I understand that all procedures will be implemented in accordance with state laws and regulations.

Print Provider Name/Credentials: _____

Provider Signature _____

Date _____