



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

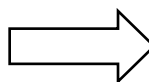
Any SEVERE SYMPTOMS after suspected or known ingestion:

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:

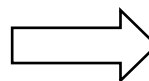
- SKIN: hives itchy rashes, swelling (e.g. eyes, lips)
- GUT: Vomiting, diarrhea, cramping pain



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



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 _____



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 _____