St. Dominic Catholic School

EMERGENCY FOOD ALLERGY AND SEVERE ALLERGY RESPONSE PLAN (AAP)

TO BE COMPLETED BY PARENT:

STUDENT INFORMATION (PLEASE PRINT)

Student Name: _____ DOB: _____

CHECK ALL SEVERE ALLERGIES:

- ❑ Insect Stings (List type) _____
- ❑ Food (List type) _____
- ❑ Environmental substances_____
- ❑ Dyes_____
- ❑ Latex_____
- ❑ Animal (List type) _____
- ❑ Medications
- ❑ Other (List) _____

CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK

- ❑ Difficulty Breathing
- ❑ Difficulty in Swallowing
- ❑ Loss of Consciousness
- ❑ Rash
- ❑ Nausea
- ❑ Swelling: How much? _____ Where ? _____
- ❑ Flushed or unusually pale skin
- ❑ Other (List) _____

Has hospitalization been needed in the past year for allergies? _____ NO _____ YES; Date: _____

Are medications needed for allergy(ies) ? _____ NO _____YES; List _____

Healthcare Provider form must be completed for administration of medication

Any other information:_____

My signature allows permission to include my child's picture with this plan. I give permission for my child to administer, be administered or assisted in the self-administration of the Epi-Pen by authorized persons. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider regarding any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the Epi-Pen.

_____ _____

Parent/Guardian Signature Date

St. Dominic Catholic School

HEALTHCARE PROVIDER FORM FOR AN ALLERGY ATTACK

Student Name: _____

ALLERGIES: _____

Asthmatic: Yes ☐ No ☐ High risk for severe reaction ☐

SIGNS OF AN ALLERGIC REACTION

Systems:	Symptoms:
• **MOUTH**	itching & swelling of the lips, tongue, or mouth.
• **THROAT**	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
• **SKIN**	hives, itchy rash, and/or swelling about the face or **extremities.**
• **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea.
• **LUNG**	shortness of breath, repetitive coughing, and/or wheezing.
• **HEART**	thready pulse, passing-out.

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

HEALTHCARE PROVIDER ORDER FOR MINOR REACTION:

1. If symptom (s) is/are :_____,give_____
Medication/dose/route

2. Notify parent or emergency contact of medication administration. .

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

HEALTHCARE PROVIDER ORDER FOR MAJOR REACTION:

If symptom(s) is/are:_____

Give_____**IMMEDIATELY!**
Medication/dose/route

1. CALL 911 IF EPIPEN ADMINISTERED

2. Notify parent/guardian or emergency contact.

_____ _____
Date Healthcare Provider's Signature

_____ _____ _____
Print Healthcare Provider's Name Address Telephone Number

ddb 2020