ALLERGY ACTION PLAN (AAP) & QUESTIONNAIRE

School Year_____

Student Name_____ DOB_____

School_____ Room_____ Teacher_____

Place Student Picture Here

(Face Only)

Page 2 of this form must be signed and dated by <u>both</u> the parent and the treating physician or licensed prescriber annually. The parent/guardian is responsible for supplying all ordered medication. Additional paperwork may be needed for food allergies, asthma action plans, asthma medications, etc.

***Food Paperwork May be Needed** ****Asthma Action Plan Form Needed** *****Authorization for Medication Form Needed**

Parent/Guardian and Emergency Contact Information

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Emergency Contact (If parent/guardian cannot be reached)

Name_____ Relationship_____ Phone_____

Allergic History Questionnaire

1. Has a doctor diagnosed your child's allergies? ☐ Yes or ☐ No
2. Which of the following is your child allergic to? Please list:
   - ❑ **Nuts**: Check one: ▢ Peanuts **or** ▢ Tree Nuts **or** ▢ Both Peanuts **and** Tree Nuts
   - ❑ **Other Foods***:_____
   - ❑ Environmentals (trees, pollen, etc.): _____
   - ❑ Animals: _____
   - ❑ Medications: _____
   - ❑ Other (insect bites/stings, latex, etc): _____
3. What happens to your child during an allergic reaction? _____
4. Does your child need special care during an allergic reaction? ▢ Yes or ▢ No

   If Yes, what special care does your child need? _____
5. Is your child currently taking any medications for allergies? ▢ Yes or ▢ No

   If Yes, please list all medications: _____
6. Does your child need medication at school for treatment of an allergic reaction? ▢ **Yes*** ** or ▢ No
7. Is there anything else we need to know about your child's allergies? _____
8. Does your child have Eczema? ▢ Yes or ▢ No
9. Does your child have a history of Asthma? ▢ Yes, higher risk of severe allergic reaction ▢ No

   If Yes, please complete a separate ****Asthma Action Plan** and *****Authorization for Medication Form** for asthma medications needed at school
10. Does your child have a history of Anaphylactic Reaction? ▢ Yes ▢ No

    If Yes, was an Epinephrine injection given? ▢ Yes ▢ No

    If Yes, please describe reaction_____

Allergy Action Plan Details

Extremely reactive to the following:_____ **THEREFORE:**

- ▢ If checked, give epinephrine immediately for ANY symptoms if student was LIKELY exposed to an allergen
- ▢ If checked, give epinephrine immediately if student was DEFINITELY exposed to an allergen even if NO symptoms

Any **SEVERE SYMPTOMS** after a suspected or known ingestion and/or known allergen was eaten if no symptoms:

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 breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body, widespread redness, itching, swelling (e.g., eyes, lips, etc)
GUT:	Repetitive vomiting, severe diarrhea

Or **combination** of symptoms from different body areas:

1. **Inject Epinephrine Immediately**
2. **Call 911**, then parent/guardian
3. Remain with student and monitor
4. * Give additional medication as ordered
   - 2nd dose of epinephrine (if necessary)
   - Antihistamine and/or inhaler
5. Student should remain calm/quiet (if possible have student lie down with legs elevated)
6. Monitor student for nausea/vomiting (roll student onto their side to protect airway)

* Antihistamines & inhalers 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 if ordered**
2. Stay with student; Call parent/guardian
3. If symptoms progress and worsen: **USE EPINEPHRINE** (Follow above instruction)

I am in agreement and authorize the medication/plan as stated in this two page plan (see page 1)

Antihistamine Name_____Dose_____

Route: _____ Frequency:_____

Epinephrine dose: ▢ 0.3 mg (Regular) ▢ 0.15 mg (Junior)

- Two doses are to be made available at school by parent/guardian: ▢ Yes ▢ No
- A second dose of epinephrine can be given 5 minutes or more, after the first dose if symptoms persist, recur, or worsen ▢ Yes ▢ No
- This student is both capable and responsible to self-carry Epinephrine: ▢ Yes ▢ No
  Parent/guardian Initials_____ Physician Initials_____
- If student is to self-carry his/her epinephrine, help may still be needed to administer medication
- If student is to self carry epinephrine, school will need to be supplied with a back up auto-injector

Physician Signature_____**Date**_____

Print Physicians Name_____Phone_____

Address_____City/State_____Zip Code_____

Parent/Guardian Signature_____**Date**_____