Parent Information Packet: Insect-Environmental Allergies Documentation Requested

To the parent of _____ Date: _____

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may be allergic to insect stings/environmental allergens.

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special observation for this condition at school.

Please complete the section below and return to me at school. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

_____
School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

____ This is not a health concern for my child.
____ My child is allergic to: _____
His/her symptoms are: _____
Treatment of the sting is: _____
___ Local, with application of baking soda, ice, etc.
___ Oral, with a medication such as Benadryl
___ Injection, such as Epi Pen
What medication do we need to have at school?_____

Name of your child's Arizona Licensed Physician/Health Care Provider _____
Phone _____

PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:

- ☑ **Insect/Environmental Allergies Medical Management Plan for School** Form signed by an **Arizona Licensed Physician/Health Care Provider** and parent/guardian**:** If student requires an Epi-Pen
- ☑ **Please see school health staff if your child requires medications to be given at school.**

_____ _____ _____
_____ _____ _____
Name of Parent and/or Guardian Signature Date

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SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Insect/Environmental Allergies Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by **Arizona Licensed Physician/Health Care Provider**

Student's Name:_____**D.O.B:**_____**Teacher:**_____
ALLERGY TO:_____
Asthmatic ____Yes ____No *Higher risk for severe reaction

***** STEP 1: TREATMENT *****

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
* If a food allergen has been ingested, but *no symptoms*:	☐Epinephrine ☐Antihistamine
* Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine ☐Antihistamine
* Skin: Hives, itchy rash, swelling of the face or extremities	☐Epinephrine ☐Antihistamine
* Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine ☐Antihistamine
* Throat†: Tightening of throat, hoarseness, hacking cough	☐Epinephrine ☐Antihistamine
* Lung†: Shortness of breath, repetitive coughing, wheezing	☐Epinephrine ☐Antihistamine
* Heart†: Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine ☐Antihistamine
* Other†: _____	☐Epinephrine ☐Antihistamine
* If reaction is progressing (several of the above areas affected), give: _____	☐Epinephrine ☐Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

*****☐STEP 2: EMERGENCY CALLS ***☐**

1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____

****Additional consent forms required for all medications to be administered during the school day