The Magellan International School
El Colegio Internacional Magallanes
麦哲伦国际学校

## Anaphylaxis / Allergic Reaction Information
## Due August 4th

Student Name: _____ Grade: _____ Academic Year: _____

Parent/Guardian_____ Phone (H)_____Phone(W)_____Phone(Cell)_____

Parent/Guardian_____ Phone (H)_____Phone(W)_____Phone(Cell)_____

Emergency contact_____Relationship_____Phone_____

Physician/Clinic_____Phone(office)_____

Does your child see another doctor/clinic for anaphylaxis/allergic reaction? □Yes □No
(If yes, please complete doctor information)?

Doctor/Clinic_____Phone(office)_____
List all medications:
Home_____

School_____

What date did you child have their first anaphylactic/allergic reaction?_____

How many anaphylactic/allergic reactions has your child had since the first reaction? _____

When was your child's last anaphylactic/allergic reaction?_____

Has your child been hospitalized due to an allergic/anaphylaxis reaction? □Yes □ No

Does your child have an Epinephrine auto- injector? □Yes □ No

Does your child have asthma? □Yes □ No

**What triggers an anaphylaxis/allergic reaction in your child?** (Check all that apply)

□ Bee/Wasp sting
□ Ant Bite
□ Other Insect Sting_____
□ Peanuts
□ Tree Nuts
□ Other Nuts_____
□ Wheat
□ Soy
□ Milk
□ Eggs
□ Fish
□ Shellfish
□ Other Foods_____
□ Other Foods_____
□ Other Foods_____
□Plants, flowers, cut grass, pollen
□ Other_____
□ Other_____
□ Other: _____

**Describe the symptoms your child experiences before or during an anaphylaxis/allergic reaction.** (Check all that apply)

□ Hives
□ Difficulty Breathing
□ Paleness
□ Complaint of tingling, itchiness, or metallic taste in the mouth
□ Vomiting
□ Cramps/Stomach Pain
□ Diarrhea
□ Swelling/itching of the or throat area
□ Loss of consciousness
□ Other_____
□ Other _____
□ Other_____

**Authorization for Release of Medical Information:**

I hereby authorize_____ to furnish anaphylaxis/allergic
(Clinic/Provider)

reaction related information regarding my child _____ to the Student
Student's Name School

Heath Services personnel at The Magellan International School.

_____ _____ _____
Parent/Guardian Signature Print Name Date

I give permission for the school nurse to communicate with my child's doctor concerning their anaphylaxis/allergic reaction and its treatment .

_____ _____ _____
Parent/Guardian Signature Print Name Date

Please provide the action plan from your physician (sample below):

**ALLERGY/ANAPHYLAXIS PHYSICIAN ORDERS**

Student Name:_____ Date of Birth:_____ School Name: _____Teacher:_____

ALLERGY TO:_____

Asthmatic □Yes □ No
**Higher risk for severe reaction

**STEP 1: TREATMENT**

| **Symptoms:** | ****Give Checked Medication:**<br>(** 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 |

**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)_____
4. Emergency contacts:
Name/Relationship Phone Number(s)
a. _____ 1.)_____ 2.) _____
b. _____1.)_____2.) _____
EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY! Form in compliance with SB27

Parent/Guardian's Signature_____ Date_____
Doctor's Signature_____ Date_____
(Required)