WONEWOC-CENTER SCHOOLS STUDENT ALLERGY INFORMATION FORM

Student_____ **Date of Birth**_____
Grade_____ **Teacher**_____ **School Year**_____
Parent/Guardian_____ **Phone Number**_____
Practitioner_____ **Phone Number**_____

Please answer the following questions about your child's allergy(ies) and reaction:

1. What is your child allergic to? Exposed by being stung, ingesting, inhaling, or skin contact? (circle)
   _____

2. Please indicate the severity of the reaction (circle one).
   (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3. Indicate how **your** child reacts to the allergen and how to treat symptoms.

❑ Exposed, but no symptoms	Antihistamine	Epinephrine/Call 911
❑ Hives, itchy rash	Antihistamine	Epinephrine/Call 911
❑ Nausea, abdominal cramps, vomiting, and/or diarrhea.	Antihistamine	Epinephrine/Call 911
❑ Itching & swelling of the lips, tongue or mouth.	Antihistamine	Epinephrine/Call 911
❑ Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough. ***	Antihistamine	Epinephrine/Call 911
❑ Shortness of breath, repetitive coughing, and/or wheezing. ***	Antihistamine	Epinephrine/Call 911
❑ "Thready" pulse, "passing out". ***	Antihistamine	Epinephrine/Call 911
❑ Other_____	Antihistamine	Epinephrine/Call 911

*** Potentially Life-threatening. Severity of symptoms can change quickly --- CALL 9-1-1!!
Additional directions: _____

4. How quickly do symptoms appear after exposure to allergen?
   _____seconds _____minutes _____hours

5. Does your child carry his/her own Epinephrine Auto-injector? _____Yes_____No
   a. Brand of injector? EpiPen EpiPen Jr Auvi-Q 0.3mg Auvi-Q 0.15mg Other_____
   b. Has she/he been instructed on how to administer EpiPen? _____Yes _____No
   c. Does she/he administer his/her own shot? _____Yes _____No

6. Does your child take Benadryl for their allergy? _____Yes _____No
   a. Give Benadryl before EpiPen? _____Yes _____No
   b. Give Benadryl after EpiPen _____Yes _____No
   c. Give Benadryl only? _____Yes _____No
   d. Dose to be given _____teaspoon(s) _____tablet(s)

7. For **<u>food</u>** allergies:
   a. Is your child able to avoid exposure to unsafe foods? _____Yes _____No
   b. Does your child know their symptoms of an allergic reaction? _____Yes _____No
   c. Does your child know how and when to tell an adult they may be having an allergic reaction? _____Yes _____No

8. For **<u>other</u>** allergies:
   a. Does your child know their symptoms of an allergic reaction? _____Yes _____No
   b. Does your child know how and when to tell an adult they may be having an allergic reaction? _____Yes _____No

Continued on back

Epinephrine will be administered for any suspicion of respiratory symptoms. Early treatment with epinephrine is the most effective.

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication be administered by school personnel.
- I understand that medication may be given by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian.
- I will pick up unused medications at the end of the school year. Unclaimed medications will be discarded.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- This student is capable of self-administration and may carry EPI pen and self-administer in school.
  ☐Yes ☐No

_____ _____

Signature of Parent/Legal Guardian Date

PHYSICIAN ORDER:

The above medication(s) is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication may be given by non-medically trained school personnel. Please contact me if the following symptoms occur:

_____

This student is capable of self-administration and may carry EPI pen and self-administer in school.
☐Yes ☐No

_____ _____ _____

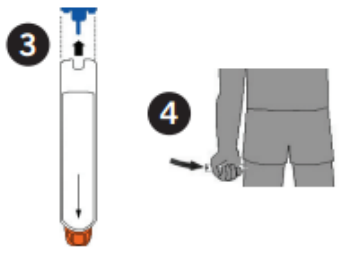
Physician Printed Name Address Phone

_____ _____

Signature of Physician Date

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.