Tempe Union High School District
Request for Medical Documentation – Allergy and Anaphylaxis

Student's Name:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each school year. The forms attached are:

1. Allergy History form, to be filled out by the parent
2. FARE Care Plan, to be filled out by parent and licensed health care provider
3. Consent for Medication Administration Form, to be filled out by parent and licensed health care provider

If you would like to request a meeting with the nurse regarding your student's health care needs, please let me know and I will arrange a meeting.

Please complete the Consent for Medication Administration Form. Students are allowed to carry emergency anaphylaxis medications in school, if the licensed health care provider and parent deems them capable of doing so. These medications can also be kept in the health office.

All completed paperwork and supplies needed to care for your student must be brought to school prior to your student's first day.

Feel free to contact your school health office with any questions.

Thank you,

Tempe Union High School District
ALLERGY HISTORY

Student Name _____ DOB _____
ID Number _____ Date _____

TYPE OF ALLERGY

Check the box next to any allergy your student has experienced and list name/s as requested.

☐ **Medication student is allergic to**

_____

☐ **Name of specific food**

_____

☐ **Environmental allergens dust, mites, mold, pets, etc.**

_____

☐ **Insect bites/stings**

_____

SYMPTOMS OF ALLERGY

Check the box next to any symptoms your student has experienced.

☐ Hives

☐ Swelling of _____

☐ Difficulty in breathing - wheezing

☐ Difficulty swallowing

☐ Shock

☐ Fainting - dizziness

☐ Other (describe) _____

_____

1. Has your student seen a doctor for any of the allergies indicated above? ☐ Yes ☐ No
2. Has your student ever been hospitalized for any allergic event? ☐ Yes ☐ No Describe _____
3. Is medication required immediately after exposure to any allergy producing substance? ☐ Yes ☐ No
   If Yes, **name of medication** _____

   If the medication is to be carried by the student, it must be noted in the health office. If the medication is to be kept in the health office, a Consent for Medication form must be on file.
4. If no medication is necessary, how should the school treat the allergic event?

   Careful observation ☐ Yes ☐ No

   Call parent/guardian ☐ Yes ☐ No

Are any classroom accommodations needed?

_____

Parent/Guardian Name (Print) _____ Phone No. _____

Parent/Guardian Signature _____ Date _____

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs.

Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.**

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] **If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

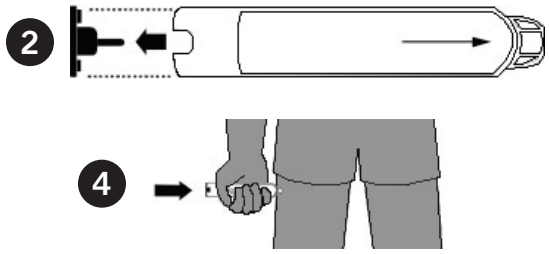
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

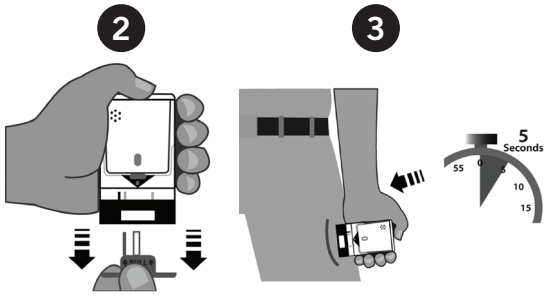
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year _____ to _____

Student Name _____

School _____ **Student ID** _____

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: _____ **Phone No.** _____
(Please print)

_____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

_____
Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

_____
Parent/Guardian Signature **Date**