

Annual Severe Allergy Survey – Parent Information

School Year: _____

Please provide us with current information about your child's allergies. If there are questions, your school nurse will follow up with you.

Student Name: _____ Grade: _____

1. Please indicate what your child is allergic to by checking the appropriate box:

- Peanuts Bee Sting Tree Nuts
 Latex Milk Other: _____

2. At what age did your child experience their first allergic reaction? _____

3. Please describe the type of allergic reaction he/she has had in the past:

- itching, tingling, or swelling of lips, tongue, mouth
 hives, itchy rash, swelling of the face or extremities
 nausea, abdominal cramps, vomiting, diarrhea
 tightening of throat, hoarseness, hacking cough
 shortness of breath, repetitive coughing, wheezing
 fainting, pale, blueness
 other: _____

4. Has your child seen a doctor for this allergy? Yes No

5. Has your child been seen at an emergency room because of an allergic reaction, and if so, what medication was given?

6. When was the last time your child had an allergic reaction? _____

7. How do you treat allergic reactions at home? _____

8. Does your child have an Epi-Pen at home? Yes No

9. If yes, does your child know how to use the Epi-Pen? Yes No

10. Please indicate when your child reacts to the allergen by checking the appropriate box:

- eats it inhales it touches it Other: _____

11. May we share your child's allergy information with his/her classmates? Yes No

Parent Signature _____ Date _____

**PLACE
PICTURE
HERE**

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [] **Yes (higher risk for a severe reaction)** [] **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

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

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

FOR ANY OF THE FOLLOWING:

SEVERE 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, severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	<p>OR A COMBINATION of symptoms from different body areas.</p>

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

 NOSE Itchy/runny nose, sneezing	 MOUTH Itchy mouth	 SKIN A few hives, mild itch	 GUT Mild nausea/discomfort
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FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch 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: _____

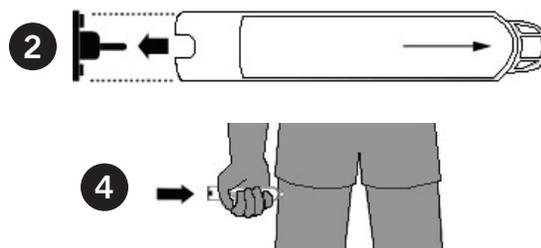
Antihistamine Dose: _____

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

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

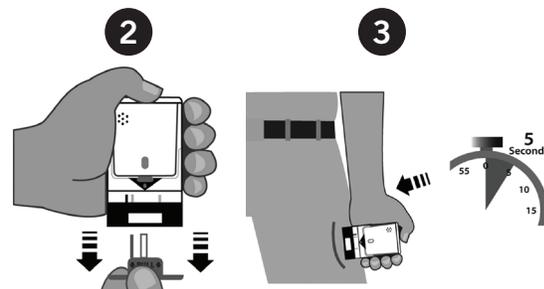
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 the person 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