Joseph L. McCourt Middle School
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Physician's Anaphylaxis Alert

Dear Parent/Guardian of: ____

Your child has been identified as having a severe allergy to ______________________________. In order to best meet his/her health care needs, you and your physician are required to complete and sign the attached questionnaire, as well as the enclosed Emergency Allergy Action Plan and the Individualized Allergy Health Care Plan.

Thank you,

______________________________ ______________________________
Certified School Nurse/Teacher E. James Monti, MD

Student Name: ____ DOB: __________________

School: ______________________________ Grade: ___ Teacher/Homeroom: ______________

****To Be Completed by Physician****

Allergen(s): ____

Child ***tested*** positive to this allergen: Yes: __________ No: __________
Child ***had a reaction to*** this allergen: Yes: __________ No: __________

Describe Reaction: ____

Child had an ***anaphylactic reaction*** to this allergen: Yes: _________ No: __________

Describe Reaction:

____

____

____

____

Physician Signature: ____ Date: __________

Parent Signature: ____ Date: __________

Student Name: ____

Allergy To: ____

For easy identification in an emergency, place a close up picture of your child's face in this box.

Cumberland Allergy Individualized Health Care Plan:

Action for Minor Reactions:

If symptom(s) are: ____________________________, give: __________________*.

(medication/dose/route)
*Always call the parent, whether it is a minor or major reaction.
*If condition worsens or doesn't improve within 5 minutes, follow steps for major reaction.

Action for Major Reactions:

If ingestion/sting is suspected and/or symptoms are:____________________________,
Give: ___________________________________(med/dose/route) Immediately. Then:

1. **Call 911**(ask for advanced life support). **DO NOT HESITATE!**

2. Call emergency contact list:

Contact 1:_________________________Phone: __________, __________, __________.
(Full Name and Relationship) (Home)
(Work) (Cell)

Contact 2:_________________________Phone:__________, __________, __________.
(Full Name and Relationship) (Home)
(Work) (Cell)

***It is the parent's responsibility to notify the bus company of any life-threatening allergy that your child has.** (Please place a check in any of the appropriate circles below)

○ My child requires a peanut-free table for meals and snacks.

○ My child requires a peanut-free classroom.

In the absence of a School Nurse/Teacher, the EPI-PEN will be administered immediately by a trained staff person in the event that there is ANY suspicion of exposure to the allergen.

Health Care Provider: PLEASE fill Allergy Plan out completely.

Physician Signature: ______________________________Date: __________________

Parent Signature: _________________________________Date: __________________

Emergency Allergy Action Plan

Place Child's Picture Here

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
(see reverse side for instructions)

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 (or Rescue Squad: ___________). 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!

Parent/Guardian's Signature____ Date______________________

Doctor's Signature____ Date______________________
(Required)