

LETTER TO PARENTS ALLERGIC REACTIONS

TO: Parents
FROM: Clinic Staff
DATE: _____
SUBJECT: Allergic Reactions

The health care forms you submitted for _____

indicate he/she has an allergic reaction to _____.

The school would appreciate the following:

1. A signed letter from your doctor with instructions the school is to follow in the event that your child experiences an allergic reaction while at school. You may elect to fill out and return the enclosed ALLERGY ACTION PLAN.
2. In the event your child has a food allergy, please provide written documentation regarding the food allergy, including a list of specific foods to be avoided (i.e., dairy: cottage cheese, sour cream, milk, etc.) as well as any additional information that will assist us in caring for your child.
3. Two epinephrine kits, if prescribed (EpiPen or Twinject), or other medication to be used if an allergic reaction occurs.

Your speedy attention to the above matter is appreciated. We would welcome an opportunity to meet with you to discuss your child's allergy and how we can implement a personalized health management plan. Please contact me at _____.

Enclosure

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____

DOB _____

Teacher _____

Allergy to _____

Asthmatic? Yes* No *Higher risk for severe reaction

STUDENT
PHOTO

STEP 1 - TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

The severity of symptoms can quickly change. †Potentially life threatening.

Symptoms

- ◆ If a student has been exposed to/ingested an allergen but has NO symptoms: _____
- ◆ Mouth Itching, tingling, or swelling of lips, tongue, mouth: _____
- ◆ Skin Hives, itchy rash, swelling of the face or extremities: _____
- ◆ Gut Nausea, abdominal cramps, vomiting, diarrhea: _____
- ◆ Throat† Tightening of throat, hoarseness, hacking cough: _____
- ◆ Lung† Shortness of breath, repetitive coughing, wheezing: _____
- ◆ Heart† Thready pulse, low blood pressure, fainting, pale, blueness: _____
- ◆ Other† _____
- ◆ If reaction is progressing, (several of the above areas affected), give: _____

Give Checked Medication**

***To be determined by physician authorizing treatment*

<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
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<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

DOSAGE

START DATE _____

END DATE _____

Epinephrine: Inject intramuscularly. See reverse side for instructions.

- EpiPen®
- EpiPen® Jr.
- Twinject 0.3mg
- Twinject 0.15mg

Antihistamine: Give _____

Important: *Ashma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.*

Other: Give _____

medication/dose/route

Special Instructions (for health care provider to complete): _____

STEP 2 - EMERGENCY CALLS

PARAMEDICS MUST BE CALLED IF EPIPEN OR TWINJECT IS GIVEN. EPIPEN OR TWINJECT ONLY LAST 15-20 MINUTES.

1. Call 911 (or Rescue Squad _____). State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Twinject) and that additional epinephrine may be needed.

2. Parents _____ Tel _____

3. Physician _____ Tel _____

Allergies

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EMERGENCY CONTACTS

1. _____
Tel: _____
2. _____
Tel: _____
3. _____
Tel: _____

Relation: _____

Relation: _____

Relation: _____

TRAINED STAFF MEMBERS

1. _____
2. _____

Room: _____

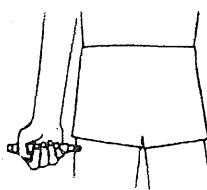
Room: _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



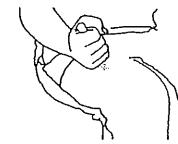
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions



- Pull off green end cap, then red end cap.

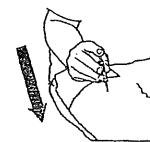
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



For children with multiple food allergies, use one form for each food.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____

Date _____

Physician Signature _____

(Required)

Date _____

Allergies

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