Jackson Township Public Schools

Allergy Information Form

Attach Student's Picture here.

Name of School: _____

School Year: 20_____20 _____

Student's Name:_____Lunch Time/Period:_____

Teacher/Homeroom: _____Grade:_____

Parent/Guardian Contact:_____

Phone Number(s):_____

Severe Allergy: NO_____ *YES____ EpiPen: NO____ * YES____

Student Self-Administer: ____NO ____*YES

If Yes, please specify:_____

Allergy *(or Health-related restriction)*	Possible Reaction
1._____	1._____
2._____	2._____
3._____	3._____

❖This form must be updated annually. Food allergies and Lactose Intolerance require annually updated healthcare provider documentation. Please attach to this form.

I give my permission for this form to be released to individuals listed below. In the event that the school nurse is not available, I give permission for the assigned delegates to administer epinephrine.

Parent/Guardian Signature:_____Date: _____

Distribution:		
	School Nurse:	Form with photo and all original doctor's notes
	Kitchen Lead:	Form with photo and copy of lactose intolerance note
	Principal:	Form with photo
	Teacher:	Form with photo
	Delegate:	Form with photo

Individual Emergency Health Plan

Attach student's picture here.

Student's Name:_____D.O.B:_____

Grade_____Teacher_____

ALLERGY TO:_____

Asthmatic *Yes☐ No☐ Unknown ☐ *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
▪ 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 a reaction is progressing (several of the above areas affected), give:	☐Epinephrine	☐Antihistamine

❖Potentially life-threatening; the severity of symptoms can quickly change.
**Delegate not permitted to administer antihistamine

DOSAGE

Epinephrine: Inject intramuscularly (circle one) Epipen® Epipen®Jr. Twinject®0.3 mg Twinject®0.15 mg

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 [redacted] -state that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____Phone Number:_____

3. Parent _____Phone Number:_____

4. Emergency contacts: Name/Relationship/Phone Number(s)

a._____1._____(Home) 2._____(Cell)

b._____1._____(Home) 2._____(Cell)

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)