# Arizona Autism Charter School
## 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 we can arrange a meeting.

Please complete the 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,

Jessica Mangieri, RN, BSN
AZACS School Nurse

**Arizona Autism Charter School**
**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

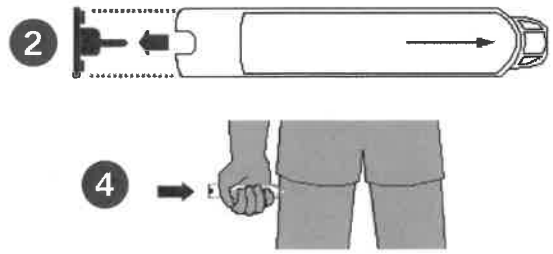
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

# FARE Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

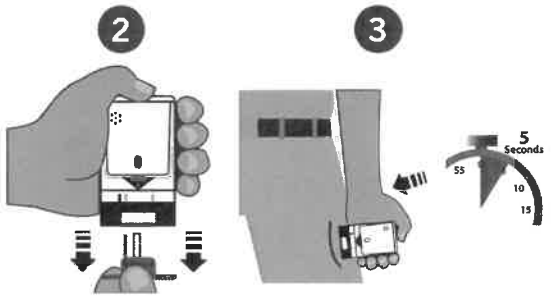
## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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

ARIZONA AUTISM
CHARTER SCHOOLS, INC

# Medication Administration in School

| Child's Name: | | Date of Birth: |
|---|---|---|
| Name of Medication: | Dosage: | Time: |

**I request that authorized school staff give my child the medication noted above, according to the Heath Care Provider's signed instruction on the lower part of this form.**

The School agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

**Prescription Medications:** must come in a container labeled with child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

**Over the Counter Medication:** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school staff delegated to administer medication.

SIGN HERE

| Parent/ Legal Guardian Name | Signature | Date |
|---|---|---|
| Work Phone | Cell Phone | |

## Health Care Provider Authorization to Administer Medication in School

| Child's Name: | DOB: |
|---|---|
| Medication: | |
| Dosage: | Route: |
| To be given at the following time(s): | |
| Special Instructions: | |
| Purpose of medication: | |
| Side effects that need to be reported: | |
| Start Date: | End Date: |

SIGN HERE

| Signature of Health Care Provider with Prescriptive Authority | License Number |
|---|---|

Phone Number_____ *Date*_____

***Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!***