



# BELLEVUE CHRISTIAN SCHOOL

## Student Severe Allergy Action Plan

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell/work: \_\_\_\_\_

Name of Health Care Provider treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_

Has your child's health care provider indicated that the food allergy may be **life-threatening**?  No  Yes  
(If YES, please complete this form and talk with the office staff before your child begins attending school.)

Would you like to talk with Mr. Kennedy and your child's teacher about a **nut free class**?  No  Yes  
OR about allowing nuts in class with certain restrictions and precautions?  No  Yes

### History and Current Status

To which foods is your child allergic?

Peanuts     Eggs     Wheat     Fish  
 Tree Nuts     Dairy     Soy     Shellfish

Please list any others: \_\_\_\_\_

How many times has your child had a reaction?  Never     Once     More than once, please explain:  
\_\_\_\_\_

Does your child also have asthma?  No  Yes (may trigger a more severe reaction)

### Triggers and Symptoms

Does your child understand how to avoid foods that cause allergic reactions?

No     Yes     Yes, with adult supervision/assistance

To what extent does your child avoid the allergenic foods in their diet? (check all that apply)

Complete avoidance of all forms of the allergenic food  
 Avoiding foods with cross contamination warnings/risk  
 Able to tolerate certain forms of the food, please explain: \_\_\_\_\_  
\_\_\_\_\_

Other than foods brought from home, which foods would your child be able to eat at school?

Commercially prepared foods with ingredient labels that are checked first  No  Yes

Homemade foods brought by others, if ingredients are known  No  Yes

Other, please explain: \_\_\_\_\_

Under what circumstance does your child react to the problem food(s)? (check all that apply)

Eating foods     Touching foods     Smelling foods     Other, please explain: \_\_\_\_\_  
\_\_\_\_\_

What are the signs and symptoms of your child's allergic reaction? (Be specific; include the things student might say) \_\_\_\_\_

How quickly do the signs and symptoms appear after exposure to the food(s)?  
\_\_\_ Seconds      \_\_\_ Minutes      \_\_\_ Hours      \_\_\_ Days

#### Treatment

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?  
\_\_\_ No    \_\_\_ Yes, please explain: \_\_\_\_\_

What treatment or medication has your health care provider recommended for use in an allergic reaction?  
\_\_\_\_\_

Does this medication need to be available **at school**? \_\_\_ No    \_\_\_ Yes (If yes, please fill out an **Oral Medication Authorization Form** found on the Three Points website and turn it **and** the medication in to the office before your child begins attending school.)

Does your child need to carry the medication on their person? (Otherwise medications are kept in the school office) \_\_\_ No    \_\_\_ Yes

Does your child need to have the medication available to them in the classroom? \_\_\_ No    \_\_\_ Yes

Does your child need to have the medication available to them on the bus? \_\_\_ No    \_\_\_ Yes

Have you administered the treatment? \_\_\_ No    \_\_\_ Yes

Is there anything else you'd like us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A copy of this plan will be kept with your child's emergency contact form in the office and a copy will be given to your child's teacher(s).

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

#### **ACTION PLAN**

**GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**

- ♦ NOTE TIME \_\_\_\_\_AM/PM (Epinephrine given)♦NOTE TIME \_\_\_\_\_AM/PM (Antihistamine given)
  - CALL 911 IMMEDIATELY. 911 must be called **WHENEVER** Epinephrine is administered.
  - **DO NOT HESITATE to administer Epinephrine and to call 911, even if the parents cannot be reached.**
  - Advise 911 that student is having a severe allergic reaction and Epinephrine is being administered.
  - An adult trained in CPR is to stay with student to monitor and begin CPR if necessary.
- ♦ Student to remain with a CPR trained staff member at location where symptoms began until EMS arrives.
- ♦ Notify the Mr. Kennedy and/or the office and parent/guardian.
- ♦ Dispose of used auto-injector in "sharps" container or give to EMS along with a copy of the Care Plan.