CHINO VALLEY UNIFIED SCHOOL DISTRICT

5130 Riverside Drive, Chino, CA 91710-4130
(909) 628-1201 FAX: (909) 548-6090 (Health Services)

Student Achievement ◆ Safe Schools
Positive School Climate

Food Allergy History (12-09)

To the parent/guardian of: _____ Date: _____

School: _____ Teacher: _____ Grade: _____

According to school records your child has an allergy to the following food(s): _____.

The school needs the following information so that we can be ready to assist your child in case of a reaction to that/those food(s). Immediate care may be of an emergency nature.

1. Approximate date of last reaction _____
2. Type of reaction _____
3. Was your child seen by a doctor or a hospital emergency room for this? ☐ Yes ☐ No
4. Name of doctor/hospital _____
5. What treatment was given _____
6. Has your child had allergy desensitization treatments (allergy shots)? ☐Yes ☐No
7. Do you have medication(s) at home in case of a food reaction? ☐Yes ☐ No

   Name(s) of medication(s) _____

   Dosage of medication(s) _____

   When is medication given? _____

8. When a physican has recommended that oral medicine be given for a reaction to a food, it may be kept at school if a ***Medication Form*** is submitted. If your child needs oral medication at school in case of a food allergy reaction, please:
   * complete and sign the parent section of the enclosed ***Medication Form*** (or request a ***Medication Form*** if one is not enclosed)
   * have your physician complete and sign the physician section of the ***Medication Form***
   * bring this ***Food Allergy History***, the ***Medication Form***, and the medication to the Health Office

9. If an emergency injectable medication, such as the Epi-pen, is required, please have your physician complete the enclosed ***Allergy Action Plan*** and the enclosed ***Medication Form***. (Please ask for these forms if they are not enclosed.) Also, please return this ***Food Allergy History*** to the Health Office.

Parent/guardian Name _____

Home Telephone _____ Work Telephone _____

Doctor's name _____ Telephone _____

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

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ASTHMA HEALTH HISTORY/UPDATE

Dear Parent/Guardian of _____ Home Rm/Teacher _____ Grade _

According to the school records, your child has asthma. The school needs the following information in order to assist your child in case of an asthma episode. Please complete the following and return it to the School Nurse.

1. Has your child been diagnosed by a doctor as having asthma? Yes ☐ No ☐
   Is your child currently under a doctor's care for asthma? Yes ☐ No ☐
2. When was your child's last episode of wheezing or breathing difficulty? _____
3. Which of the following cause your child to have an asthma episode?

Grass	☐	Drug/Allergy	☐
Pollen	☐	Illness/Infection	☐
Animal Hair	☐	Emotions	☐
Physical Activity	☐	What kind(s)?	_____
Weather Conditions	☐	Which type(s)?	_____
Food	☐	Which food(s)?	_____
Other	☐	Explain:	_____

4. How many minutes or hours does an asthma episode usually last? _____
5. Does your child have any physical restrictions due to asthma? Yes ☐ No ☐
   If yes, were these restrictions recommended by a doctor? Yes ☐ No ☐
   What are these restrictions? _____
6. During an asthma episode, does anything help it to subside, such as rest, medications, positioning, liquids, breathing exercise, etc.? Yes ☐ No ☐
   If yes, please give details _____
7. Is your child taking any medication to control asthma? Yes ☐ No ☐
   Is medication taken daily? Yes ☐ No ☐
   Is medication taken only when needed? Yes ☐ No ☐
   Was this medication recommended by a doctor? Yes ☐ No ☐
8. If your child requires medication at school in case of an asthma episode, please:
   * sign the attached form **OR** request a medication form if not attached
   * obtain your physician's written permission for medication to be administered at school
   * return the medication form to school with the medication in its original container, including the pharmacy label.

Students identified as having asthma will be required to curtail activity and/or remain indoors in the event of a smog health advisory episode, per CVUSD Board policy.

☐ **If your child no longer has asthma**, please check this box.

Physician/City _____ Phone ( ) _____

Parent/Guardian _____ Phone ( ) _____ Work ( ) _____

Allergy Action Plan

Student Name: _____ Birth Date: _____
School: _____ Grade: _____ Teacher: _____

Place Student Photo Here

ALLERGIC TO THESE ALLERGENS: _____

☐ **Has Asthma** (increases risk for severe reaction)

☐ **Severe Allergy previously/suspected—Immediately give epinephrine & call 911– Start with Steps 2 & 3**

☐ **Mild Allergy – Itching, rash, hives – Give antihistamine, call school nurse and parent. Start with Step 1**

► STEP 1: IDENTIFICATION OF SYMPTOMS* ◄

* Send for immediate adult assistance

Symptoms:		Type of Medication to Give: (Determined by physician authorizing treatment)	
➢	If exposed to allergen, or allergen 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** –**	Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P.	☐ Epinephrine	☐ Antihistamine
➢ **Other** –**	_____	☐ Epinephrine	☐ Antihistamine
➢ If reaction is progressing (several of the above areas affected) give		☐ Epinephrine	☐ Antihistamine

**** Potentially life-threatening.** – Note: The severity of symptoms can quickly change.

► STEP 2: GIVE MEDICATIONS ◄

(Twinject™ NOT Recommended for School Use)

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen Jr® ☐ Twinject™ 0.3 mg ☐ Twinject™ 0.15 m

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

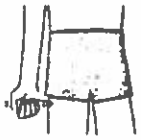
Antihistamine/other: give _____ *(Medication name & amount)* **by** _____ *(route meth*

- **Notify** parents and school nurse • **Observe** for increasing severity of symptoms • **Call 911** as needed

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction.

EpiPen Directions:

a. Pull off the GRAY Safety Cap
b. Place BLACK TIP near OUTER-UPPER THIGH
c. Swing and jab firmly until hearing or feeling a click
d. Hold EpiPen in place **10 SECONDS**, remove, massage area
e. Dispose of in red sharps container or give to paramedics



- The EpiPen can be injected through clothing.
- The individual may feel his/her heart poundin
  - This is a normal reaction to the medication.

► STEP 3: EMERGENCY CALLS ◄

1. **CALL 911** – *Seek emergency care.* State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Call School Nurse
3. Call Parents or Emergency Contacts

Parent completes Parent and Emergency Contact Names and Information below

Parents Emergency Contact *Names*:	*Relationship*:	*Phone Number(s)*:
a. _____	1.) _____	2.) ( ) _____ ( ) _____
b. _____	1.) _____	2.) ( ) _____ ( ) _____

Parent/Guardian Signature _____ Date _____
(Required)

Physician completes form through Step 2

Physician Name (Printed) _____ Phone Number: ( ) _____

Physician Signature _____ Date: _____
(Required)

This form must be renewed annually or with any change in medication.

The *Medication Administration Form* must be completed in addition to this *Allergy Action Plan*

School Phone # _____
School Fax # _____

Symptom Based – Asthma Action Plan

Student Name: _____ **Date of Birth:** _____ **School:** _____

Parent/Guardian: _____ **Home Phone:** _____ **Cellular:** _____

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home): **Please CHECK box if needed for use at school.**

A. "QUICK-RELIEF" Medication Name	1.	☐ For School *
	2.	☐ For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	1.	☐ For School *
	2.	☐ For School *
	3.	☐ For School *
C. BEFORE PE, Exertion: Med Name	1.	☐ For School *
	2.	☐ For School *

2. For student on inhaled medication (all students must go to Health Office for oral medications)
- ☐ Assist student with inhaled medication in Health Office*
- ☐ May self-administer/self-carry inhaler medication.* Student demonstrates competence. (**Not** recommended in elementary school)

3. A spacer device (e.g. Aerochamber) use is advised for all students at school.

4. Check known triggers: ☐tobacco ☐pesticides ☐animals ☐birds ☐cockroaches ☐cleansers ☐car exhaust ☐perfume ☐candles ☐mold ☐dust ☐cold air ☐exercise ☐smog ☐pollens ☐other _____

5. Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:

Green Zone

Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities

YELLOW ZONE **Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions**	**Action for school:** 1. Give "Quick – Relief" Medication(s)* 2. Notify Parent if symptoms are NOT relieved by medication after 15 - 20 min 3. If symptoms are NOT RELIEVED follow **School Emergency Plan** below 4. If symptoms are relieved, student may return to class **Notify Parent if "Quick – Relief" inhaler has been used more than two times this week (if not related to physical activity)*
RED ZONE **Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restrictions, symptoms are the same or worse after 30 minutes in Yellow Zone**	**Action for school:** 1. **Give "Quick – Relief" Medication(s)** 2. **If symptoms are not improved within 15 to 20 minutes by student's "Quick – Relief" medication, or symptoms become worse, follow School Emergency Plan below**

SCHOOL EMERGENCY PLAN

1. ***REPEAT*** "Quick-Relief" medication(s) now
2. ***Call 911*** – Seek emergency care
3. Contact parent/guardian and school nurse
4. REPEAT "Quick-Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved
5. Stay with student until paramedics arrive

Physician Name: _____ ***Physician Signature:*** _____ ***Date:*** _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ ***Date:*** _____ **Phone Number:** _____

* Medication Administration Form Required