HOLDINGFORD PUBLIC SCHOOLS – ISD #738
P.O. Box 250, Holdingford, MN. 56340

Dr. Chris Swenson	Angela Safran	Jim Stang	Garrity Gerber
Superintendent	Secondary Principal	Elementary Principal	Business Manager
320-746-2196	320-746-4309	320-746-4461	320-746-4306

Dear Parent/Guardian,

We are planning for the new school year and are aware that your child has had an allergy in the past. To ensure that we have the most accurate information to care for your child, information needs to be **updated annually**. We welcome an opportunity to meet with you and to further discuss your child's diagnosis and how we can best implement a personalized school health management plan.

This is regarding my child, _____.

- ❏ **My child's allergy to _____ is no longer a concern.**
  Please sign below and return this form to your child's school. No additional forms are needed.

  _____ _____
  Parent/guardian signature *Date*

  _____
  Print parent/guardian name

- ❏ **My child's allergy continues to be a concern.**

1. Either your doctor's Allergy Action Plan or our attached school district Allergy Action Plan must be signed by your physician and a parent/guardian. This form needs to be returned to the Health Services office as soon as possible, whether your child needs medication at school or not.
2. Complete the allergy questionnaire.
3. If medications are required, they should be brought to the Health Services office by a parent in a current-labeled container provided by your pharmacy.
4. Qualified students will be allowed to carry their own epinephrine. Complete the epinephrine contract on the parent page of the Action Plan. It is recommended to have back-up epinephrine that is kept in the Health Services office.
5. **Parents of students with severe food allergies are expected to provide safe snacks for their child.**

Please contact Kristen Bruns, School Nurse, or Kaitlyn Thell, Assistant School Nurse, with questions or concerns, or to set up a meeting to further discuss your child's health care/emergency plan. Thank you!

Kristen Bruns, RN, LSN
School Nurse, Holdingford Public Schools
kristen.bruns@isd738.org
Elementary Health Office: (320) 746-4369

Kaitlyn Thell, LPN
Assistant School Nurse, Holdingford Public Schools
kaitlyn.thell@isd738.org
High School Health Office: (320) 746-4368

Allergy Action Plan

A physician should complete the information on this page.
A parent should complete page 2.

Student Information:

Last Name:	First Name:	Date of Birth:	Grade:	School:

Parent/Guardian Information:

Parent/Guardian #1		Parent/Guardian #2	
Last Name:	First Name:	Last Name:	First Name:
Phone #1:	Phone #2:	Phone #1:	Phone #2:

Allergy to (check appropriate box and provide specifics below)**:**

▢ Peanuts ▢ Tree nuts ▢ Eggs ▢ Seafood ▢ Latex ▢ Bee/wasp Stings ▢ Other _____

Specifics:

Medications:

EPINEPHRINE (recommended to have 2 doses on hand)**:**	**ANTIHISTAMINE:**
▢ EpiPen Dose: _____ ▢ Other Name: _____ Dose: _____ **Epinephrine located:** ▢ Health Office ▢ Self-carry ▢ Backpack ▢ Other If "other" chosen, please explain:_____ **Student has been instructed how to use their epinephrine:** ▢ Yes ▢ No **If able, student will give themselves epinephrine:** ▢ Yes ▢ No ▢ If checked, give epinephrine immediately for **ANY** symptoms if the allergen was **likely** eaten. ▢ If checked, give epinephrine immediately if the allergen was **definitely** eaten, even if **no symptoms** are noted.	▢ Benadryl (AKA diphenhydramine) Dose: _____ ▢ Other antihistamine Name: _____ Dose: _____

Any SEVERE SYMPTOMS after suspected or known ingestion: **One or more** of the following: LUNG: short of breath, wheeze, repetitive cough HEART: pale, blue, faint, weak pulse, dizzy, confused THROAT: tight, hoarse, trouble breathing/swallowing MOUTH: obstructive swelling (tongue and/or lips) SKIN: many hives over body Or **combination** of symptoms from different body areas: SKIN: hives, itchy rashes GUT: vomiting, cramping-like pain	→	1. **INJECT EPINEPHRINE IMMEDIATELY!** 2. Call 911. 3. Begin monitoring (see box below). 4. Give additional medicine.* a. Antihistamine b. Inhaler if asthmatic *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.
MILD SYMPTOMS ONLY: MOUTH: itchy mouth SKIN: a few hives around mouth/face, mild itch GUT: mild nausea/discomfort	→	1. **GIVE ANTIHISTAMINE.** 2. Call parent and school nurse. 3. If symptoms progress, **INJECT EPINEPHRINE** (see above for instructions).

Monitoring

Stay with student; call parent and school nurse. Tell 911 that epinephrine was given and note time of administration.

Physician's Authorization: I authorize the above plan to be followed at school.

Physician's Printed Name:	Signature:	Date:

Last Name:	First Name:	Date of Birth:	Grade:	School:

FIELD TRIPS:

- Send prescribed medications and Action Plan.
- Call 911 if/when needed.

SELF-CARRY EPINEPHRINE CONTRACT

I give permission for my child, _____, to carry his/her epinephrine. My child understands that he/she must never share his/her epinephrine with others and that he/she must go to the health office immediately after use of epinephrine. I will notify the school of changes in medication or my child's condition. **Please note: It is recommended to have a back-up epinephrine that is kept in the health office.**

Parent/guardian signature_____ Date _____

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick the medication(s) up from the office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/guardian signature_____ Date _____

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/guardian signature_____ Date _____

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at any time in writing, and that it expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date:

Allergy Questionnaire

Last Name:	First Name:	Date of Birth:	Grade:	School:

Allergy to (check appropriate box and provide specifics below)**:**

▫ Peanuts ▫ Tree nuts ▫ Eggs ▫ Seafood ▫ Latex ▫ Bee/wasp Stings ▫ Other _____
Specifics:

1. How soon after contact does your child react? _____ minutes/ _____ hours/ _____ days
2. How often has your child been treated by a healthcare provider for an anaphylactic allergic reaction? _____
3. How many times has your child been treated with epinephrine? _____
4. When was the last time that your child was treated with epinephrine? _____
5. What are the early warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction? _____
6. Does your child recognize these signs/symptoms? ▫ Yes ▫ No
7. Does your child know how to avoid causes of allergic reactions? ▫ Yes ▫ No

Circle the symptoms that your child has shown during an allergic reaction:

- 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*
- Lungs: shortness of breath, repetitive coughing, wheezing*
- Heart: weak pulse, dizziness, fainting, pale, blue*
- Other: _____

*Potentially life-threatening

FOR FOOD ALLERGIES ONLY:
For students in grades K-6, a pictorial alert system may be used in the cafeteria and for recess supervisors if needed.

Does your child need any special precautions in the cafeteria? ▫ Yes ▫ No
If you answered “yes”, please explain:

_____

Does your child need any special precautions in the classroom in regards to:

1. Snack ▫ Yes ▫No
2. Classroom Parties ▫ Yes ▫ No
3. Food Used in Curriculum ▫ Yes ▫ No

If you answered “yes” to any of the above questions, please explain:

_____

Do you feel that your child’s allergy issues in school need to be addressed in more detail? ▫ Yes ▫ No
If you answered “yes”, please inform health office personnel.
Any additional comments:

_____