Lincoln School
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Rockaway Borough, New Jersey 07866

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Dear Parent/Guardian,

Attached please find the forms necessary for your child to have an epi-pen or other epinephrine auto-injector in school. Please have your physician complete and sign the enclosed "Physician's Order for Administration of Epinephrine for Anaphylaxis" form and return to school on or before the first day of school. If your child's physician would like your child's epi-pen to be kept in the classroom or if they would like your child to carry his or her epi-pen for self-administration, the physician must write this on the form. Please sign the parent signature portion of the form where indicated before returning. Copies of school policies regarding administration of medication and management of life threatening allergies in school are enclosed. If your child has not had an epi-pen in Lincoln School before, please contact me to set up a time we can meet to go over emergency care planning for your child.

We request that two epi-pens be provided to the school; one to be kept in the emergency Epi-Pen bag in the main office, and the other to be kept in the nurse's office, (or in your child's classroom if specified by your physician). Check with your insurance carrier to see if they cover the cost of two epi-pens for school use. Students are not permitted to carry medications of any kind into school, so please plan to either personally bring the epi-pens to school or send with another adult. Please provide a small picture of your child than can be attached to his or her emergency care plan. **If your child has a food allergy, please send in a supply of alternative treats to be stored in the classroom for your child for those occasions when the ingredients or preparation of classroom celebration treats cannot be verified.** While the district requests that treats and snacks brought in for classroom celebrations by all students be nut-free, unless you specifically state otherwise non-packaged treats sent in by others, such as home-baked items or store-bought items brought in without an ingredient list, will **not** be served to your child as there is no way the school can ensure they were prepared under allergen-safe conditions. This is for the health and safety of your child, and will also ensure your child will still be able to have something special in the event he or she cannot be served the celebration treat.

As part of an ongoing effort to ensure the safest school environment possible for your child, and to better plan for his or her care while in school, I am asking you to please complete the enclosed "Family Food Allergy Health History Form" and the "Food Allergy Questionnaire" and return them to me at your earliest convenience. These forms do not require a doctor's signature. Your answers are to be used strictly for care planning purposes and to advise your child's teachers of what foods or substances must be avoided. If you have any questions, please do not hesitate to contact me.

Thank you very much for your cooperation!

Mrs. Denise Jacobus, RN

PHYSICIAN'S WRITTEN ORDERS AND CERTIFICATION FOR CHILDREN REQUIRING ADMINISTRATION OF EPINEPHRINE FOR ANAPHYLAXIS

(To be completed by your child's physician or advanced practice nurse)

STUDENT NAME: _____ DOB _____
SCHOOL: _____GRADE:____ TEACHER:_____

Allergy Diagnosis requiring administration of epi-pen (please include the date and description of the child's previous allergic or anaphylactic reaction):_____
_____
_____

Signs of child's past allergic reaction have included (please circle)

Systems	**Symptoms**
Mouth	Itching & swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash and/or swelling about the face or extremities
GI	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing and/or wheezing
Heart	"Thready" pulse, "passing out"

Please list any additional medical conditions and/or dietary restrictions:
_____
_____
_____

Administer the following dose of epinephrine:
(Circle one): Epi-pen Jr.
Epi-pen
Other
Indications for use (please be specific):
____ For observed signs of anaphylaxis
____ Upon being stung by an insect
____ After ingestion of _____
____ Other _____

Please check one of the boxes below:
I certify that _____requires the administration of epinephrine for anaphylaxis and does not have the capability for self administration of the medication.

I certify that _____requires the administration of epinephrine for anaphylaxis and has been instructed in the safe use of epinephrine, and is capable of carrying and self administering the auto injector of epinephrine prescribed

_____ _____
Signature of physician or advanced practice nurse Date

_____
Printed name of physician or advanced practice nurse

_____
Street Address

_____ _____
City State Zip Code Phone

_____ _____
Parent/Guardian Signature Date

Allergy/Food Allergy/Dietary Restriction Questionnaire

In order to ensure the safety of your child, please complete in as much detail as possible information regarding your child's allergies, food allergies, or dietary restrictions and return this form to school as soon as possible. For food allergies or food intolerances/dietary restrictions, please specify if the food product they are allergic to needs to be avoided altogether, or if a certain type or quantity is acceptable; (for example allergy to eggs but can have baked items prepared with eggs, or lactose intolerant to milk but may have cheese pizza, etc.). It is important for us to know what can be shared safely with your child for classroom celebrations, such as holiday parties, as well as when classmates bring in treats for birthdays or other occasions. If your child has a food allergy, please send in a supply of alternative treats to be stored in the classroom for your child for those occasions when the ingredients or preparation of celebration treats cannot be verified. While the district requests that foods brought in for classroom celebrations by all students be nut-free, unless you specifically state otherwise on this form, non-packaged foods sent in by others, such as home-baked items or store-bought items, (including Dunkin Donuts/Munchkins), will not be served to your child as there is no way the school can ensure they were prepared under allergen-safe conditions. This is for the health and safety of your child, and will also ensure your child will still be able to have something special in the event he or she cannot be served the celebration treat. Thank you so much for taking the time to answer these questions. Your answers regarding what foods your child can eat or what items your child must avoid will only be shared with your child's teacher, and are otherwise kept confidential

Student name:_____ **Grade/Teacher**:_____ **Date**: _____

Dietary restriction, (not allergic, but foods student may not eat-you do not need to list reason unless you wish to do so; if student is vegetarian, please indicate if he or she follows a vegan diet, or may have dairy products or eggs):_____

Non-food allergy, (latex, chemicals, animals, insect bites, etc):_____

Symptoms of reaction to above:_____

Treatment for reaction to above:_____

My child can be in the same room/area where the above is being used ___ Yes ___No

My child can touch the item/substance listed above ____ Yes ____ No

____Food allergy ___intolerance to:_____

Symptoms of reaction to above:_____

Treatment for reaction to above:_____

My child must avoid food(s) listed above totally: _____ Yes _____No

May have a limited amount (be specific)_____

(over →)

My child may only eat foods brought in from home _____ Yes _____ No

My child may order lunch/purchase snacks from the school cafeteria _____ Yes _____ No

My child may eat Dunkin Donuts Munchkins _____Yes _____No

My child may eat Dunkin Donuts doughnuts _____Yes _____No

****My child may eat home-baked items brought in by other students for classroom celebrations that are accompanied by an ingredient list;** please remember even though the baked item has an ingredient list, the school cannot ensure the items were prepared under allergen-free conditions-for example although an item may not contain nuts, nut products may be used in the home. **____Yes _____No****

****My child may eat other non-packaged items that are *not* accompanied by an ingredient list, (i.e., home-baked items, bagels, bakery items), that are brought in by other students for classroom celebrations ____Yes ____No****

***If the answer to either or both of these questions is no, please send in a small supply of allergy-safe treats that can be stored in the classroom for your child for those occasions when the ingredients or preparation of classroom celebration treats cannot be verified*

My child may sit at the same table with other children who are eating this food/food containing this product: _____ Yes _____No

(Please be aware that a separate nut-free table is available in the school cafeteria, but other students in the cafeteria may be eating foods that contain nuts.)

My child can touch the food/food containing this product: ___ Yes _____No

My child can smell the food/food containing this product: _____Yes _____No

Is there anything else you would like the school nurse or your child's teachers to know about your child's allergies or intolerances?_____

_____

_____

_____

Parent Signature: _____

Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?
- ❑ Peanuts
- ❑ Eggs
- ❑ Milk
- ❑ Latex
- ❑ Soy
- ❑ Other: _____
- ❑ Insect Stings
- ❑ Fish/Shellfish
- ❑ Chemicals _____
- ❑ Vapors _____
- ❑ Tree Nuts (walnuts, pecans, etc.)

b. Age of student when allergy first discovered: _____
c. How many times has student had a reaction?
❑ Never ❑ Once ❑ More than once, explain:
_____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ❑ Same ❑Better ❑ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
_____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. Please check the symptoms that your child has experienced in the past:

Skin:	❑ Hives	❑ Itching	❑ Rash	❑ Flushing	❑ Swelling (face, arms, hands, legs)
Mouth:	❑ Itching	❑ Swelling (lips, tongue, mouth)			
Abdominal:	❑ Nausea	❑ Cramps	❑ Vomiting	❑ Diarrhea	
Throat:	❑ Itching	❑ Tightness	❑ Hoarseness	❑ Cough	
Lungs:	❑ Shortness of breath		❑ Repetitive Cough		❑ Wheezing
Heart:	❑ Weak pulse	❑ Loss of consciousness			

4. Treatment

a. How have past reactions been treated? _____
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____
e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
_____
f. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
g. Have you used the treatment or medication? ❑ No ❑ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

5. Self Care

a.	Is your student able to monitor and prevent their own exposures?	❑ No	❑ Yes
b.	Does your student:		
	1. Know what foods to avoid	❑ No	❑ Yes
	2. Ask about food ingredients	❑ No	❑ Yes
	3. Read and understands food labels	❑ No	❑ Yes
	4. Tell an adult immediately after an exposure	❑ No	❑ Yes
	5. Wear a medical alert bracelet, necklace, watchband	❑ No	❑ Yes
	6. Tell peers and adults about the allergy	❑ No	❑ Yes
	7. Firmly refuses a problem food	❑ No	❑ Yes
c.	Does your child know how to use emergency medication?	❑ No	❑ Yes _____
d.	Has your child ever administered their own emergency medication?	❑ No	❑ Yes _____

6. Family / Home

a.	How do you feel that the whole family is coping with your student's food allergy? _____		
b.	Does your child carry epinephrine in the event of a reaction?	❑ No	❑ Yes
c.	Has your child ever needed to administer that epinephrine?	❑ No	❑ Yes
d.	Do you feel that your child needs assistance in coping with his/her food allergy? _____		

7. General Health

a.	How is your child's general health other than having a food allergy? _____		
b.	Does your child have other health conditions? _____		
c.	Hospitalizations? _____		
d.	Does your child have a history of asthma?	❑ No	❑ Yes
	If yes, does he/she have an Asthma Action Plan?	❑ No	❑ Yes
e.	Please add anything else you would like the school to know about your child's health: _____		
	_____		

8. Notes:

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by R.N.: _____ **Date:** _____

Adapted with permission – Washington State Guidelines for Anaphylaxis