CHCNS ALLERGY ADDENDUM

Child's name (please print): _____
DOB:_____

My child is allergic to the following:_____
_____

• If your child requires medication at school, please complete and return the Medication Authorization Form for each medication needed.
• If your child has a food allergy, please complete the Food Allergy Action Plan and the Authorization & Release of Liability statement below.

EMERGENCY CALLS:
1) Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2) Call my student's Dr.
_____
at _____

3) Emergency Contacts Name/Relationship Phone Numbers:

a. _____ _____

b. _____ _____

c. _____ _____

FOOD ALLERGY ACTION PLAN

Student's Name:_____ D.O.B:_____

ALLERGY TO:_____

Asthmatic □Yes* □No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: Give Checked Medication: (To be determined by Physician authorizing treatment)

▪ If a food allergen has been ingested, but no symptoms: □EpiPen □ Antihistamine

▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth □ EpiPen □ Antihistamine

▪ Skin Hives, itchy rash, swelling of the face or extremities □EpiPen □ Antihistamine

▪ Gut Nausea, abdominal cramps, vomiting, diarrhea □EpiPen □ Antihistamine

▪ Throat* = Tightening of throat, hoarseness, hacking cough □ EpiPen □ Antihistamine

▪ Lung* = Shortness of breath, repetitive coughing, wheezing □EpiPen □ Antihistamine

▪ Heart *= Thready pulse, low blood pressure, fainting, pale, blueness □ EpiPen □ Antihistamine

▪ Other* = _____ □ EpiPen □ Antihistamine ▪ If reaction is progressing (several of the above areas affected), give □ EpiPen □ Antihistamine

*The severity of symptoms can quickly change. = Potentially life-threatening

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine:

give_____

_____medication/dose/route

Other:

give_____

_____ medication/dose/route

STEP 2: EMERGENCY CALLS

1) Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed)

2) Call Dr. listed above.

3) Call Emergency Contacts listed above

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____

Date_____

Doctor's Signature_____

Date_____

For children with multiple food allergies, consider providing separate Action Plans for different foods. **Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.

AUTHORIZATION AND RELEASE OF LIABILITY (For students with food and/or bee sting allergies that may result in anaphylaxis):

I understand that Capitol Hill Cooperative Nursery School ("CHCNS"), which is located in and operates independently of Capitol Hill United Methodist Church, cannot promise or assure that an environment be created or maintained that is free of a food and/or bees that my child is allergic to, or that he/she will not suffer an allergic reaction, despite the fact that CHCNS has taken certain precautions and asked parental cooperation in order to minimize the risk of exposure to such food and/or bees.

Nevertheless, in the event of a situation that a teacher, administrator, school nurse, staff member, or other CHCNS representative deems to be a medical emergency, I hereby authorize

them to administer care and/or emergency medications in accordance with my physician's instructions that have separately been provided to CHCNS. I understand that such care may not be administered by a trained professional.

I hereby release CHCNS and any and all of its directors, staff members, parent volunteers, or other representatives (collectively, "CHCNS Representatives") from and against any and all lawsuits, claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including but not limited to, reasonable attorney's fees (collectively, "liabilities"), that any of the CHCNS Representatives may incur or sustain, and directly or indirectly relates to, or arises from or in connection with:

1. Any allergic reaction or anaphylaxis that was or may have been caused, in whole or in part, by exposure to said allergens while at CHCNS or in connection with school-related activities or events; and,

2. Any CHCNS Representative's effort to give (or decision to refrain from giving) treatment to my child in connection with an allergic reaction or symptoms that appear to indicate an allergic reaction.

Student's Name (please):_____

Allergic to: _____

Parent/Guardian Name (please print) :_____

Parent/Guardian
Signature:_____

Date:_____