Food Allergy Action Plan

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

Place Child's Picture Here

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*:	☐ 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†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

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

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

HEALTH HISTORY
Caring for students with allergies

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

Does your child have asthma? ___ yes ___no (asthma can increase the severity of the reaction)

Other health concerns/medical problems?_____
_____

Type of allergy and reaction _____
SAMPLES: _____
(Eggs-facial rash) _____
(seafood-difficult breathing) _____
_____
_____

At what age was the student diagnosed with the allergy?_____
What symptoms led to the diagnosis?_____

Approximately how many allergic reactions has the student experienced?_____
When was his/her last allergic reaction?_____

Does the child have an early awareness of an onset of an allergic reaction?_____

What treatment does the child usually require for an allergic reaction?_____
_____

Has the child been hospitalized as a result of an allergic reaction? __Y __N
How many times?_____
_____

Has the student experienced an allergic reaction at school before?_____
If so, please describe incident: _____

Is there anything else that the school should know to take the best care we can of your student? _____
_____
_____
_____

Health care provider name: _____ **Phone:** _____

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis?
Yes_____ No_____

Parent/Guardian Signature_____ **Date**_____

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

PLEASE CHECK ONE:

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**

☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____