Food Allergy Action Plan

ALLERGY TO:____

Student's Name:______________________ D.O.B:__________ Teacher:______________

Asthmatic Yes* ☐ No ☐ *High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

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
•GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
•LUNG*	shortness of breath, repetitive coughing, and/or wheezing
•HEART*	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION FOR MINOR REACTION ◆

1. **If only symptom(s) are:**______________________________, give______________________
medication/dose/route

____

Then call:

2. Mother______________________, Father ______________________, or emergency contacts.
3. Dr. ______________________ at ______________________

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. **If ingestion is suspected and/or symptom(s) are:**______________________________,

give____ IMMEDIATELY!
medication/dose/route

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother______________________, Father ______________________, or emergency contacts.
4. Dr. ______________________ at ______________________

DO NOT HESITATE TO CALL RESCUE SQUAD!

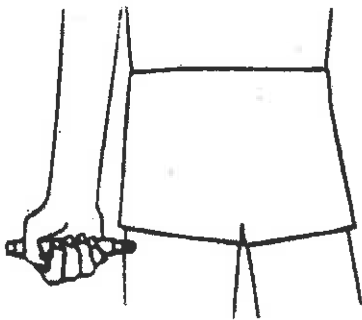
Parent's Signature______________________ Date_____ Doctor's Signature______________________ Date____

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. ______________________	1. ______________________ Room ________
Relation: ______________ Phone: ____________	
2. ______________________	2. ______________________ Room ________
Relation: ______________ Phone: ____________	3. ______________________ Room ________
3. ______________________	
Relation: ______________ Phone: ____________	

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. **Pull off gray activation cap.**

2. **Hold black tip near outer thigh (always apply to thigh).**



3. **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.**

For children with multiple food allergies, use one form for each food.

AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

______________________________ ______________________________
Name of Student | Telephone

______________________________ ______________________________
Address | Date of Birth

______________________________ ______________________________
School | Room

1. I am requesting permission for my child named above to: (Check one or both)

   _____ use or receive medication

   _____ receive treatment

   in accordance with the Doctor's prescription.

2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.

3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

______________________________ ______________________________
Signature of Parent or Adult Student | Date

______________________________ ______________________________
Home Telephone | Work Telephone

PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to ______________________________
Student

______________________________ ______________________________
Medication Dosage

Medication is to be taken at the following times ______________________________

Instructions or precautions (including possible side effects): ______________________________

____

____

____
Treatment

Beginning Date ______________________ Expiration Date ______________________

Physician ______________________ Telephone ______________________

Printed/Typed Name ______________________ Date ______________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student:

____

____

____

____
Principal