Food Allergy Action Plan

Name: _____ D.O.B.: ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ 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.

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, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*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. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

INDIVIDUAL CONSIDERATIONS

Bus – Transportation has been alerted of student's allergy □YES □NO

- Student carries EPIEPEN on the bus □YES □NO
- EPIPEN can be found in □Backpack □Purse □On person □Other_____
- Student will sit at front of bus □YES □NO
- Other (specify) _____

Classroom – For Food Allergy Only

- Student is allowed to eat only the following foods:

□ those in manufactured packaging with ingredients listed and determined to be allergen-safe by the Primary Care Physician or Parent
□ those approved by parent
□ Middle/High school students will be making his/her own decisions
□ Alternative snacks will be provided by Parent/Guardian to be kept in classroom
□ Parent/Guardian to be advised of planned parties as early as possible
□ Student to wear ID bracelet indicating ALLERGY
□ Signs posted in classroom indicating classroom free of allergen (peanuts, red dye, etc.)

Cafeteria – Alerted of student's allergy □YES □NO

- Student will:

□ NOT share or trade food items in the lunch room
□ Bring a packed lunch daily
□ Be able to identify food allergy restrictions
□ NO RESTRICTIONS

Emergency Contacts
Name: _____ Relationship: _____ Phone: _____

Preferred Hospital: _____

- I request the medication to be given as ordered by the licensed health care provider
- I give permission to communicate with school staff about my child's allergy
- Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called
- All medication must come in its originally provided container with instructions as noted above by the licensed health care provider
- I request and authorize my child to carry and/or administer their medication □YES □NO

Parent/Guardian Signature: _____ Date: _____

Student demonstrated to the nurse the skill necessary to use the medication and any device necessary to self-administer the medication.
Device(s) if any, used: _____ Expiration date(s): _____

LPN/RN Signature: _____ Date: _____