Food Allergy Action Plan

Student's Name: ____ **DOB:** _____________ **Grade:** ______________

Parent/Guardian Name: __________________________________ **Phone Number:** _________________________

Emergency Contact #1: _____________________________________ **Phone Number:** ________________________

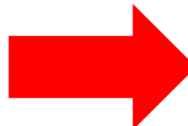
Emergency Contact #2: _____________________________________ **Phone Number**: _______________________

Primary Physician: ______________________________________ **Phone Number:** _________________________

ALLERGIC TO: ____

Asthma: ______ Yes (higher risk for a severe reaction) _____ No Weight: _________lbs]

IF ACCIDENTALLY INGESTED, SEVERE SYMPTOMS INCLUDE:
Lung: short of breath, wheeze, repetitive cough
Heart: pale, blue, faint, weak pulse, dizzy, confused
Throat: tight, hoarse, trouble breathing/swallowing
Skin: many hives over body
Or combination of symptoms from different body areas:
Skin: hives, itchy rash, swelling
Gut: vomiting, cramping stomach pain



Inject Epinephrine Immediately:

- **Call 911**
- **Begin monitoring**
- **Contact parent/guardian**
- **Additional Medications, if ordered:**
  - **Antihistamines**
  - **Inhaler**

MILD SYMPTOMS ONLY:
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch

Give Antihistamine
Stay with child, alert school nurse and parent. If symptoms progress, see above protocol.

___ Skip antihistamine protocol and give epinephrine for ANY symptoms if the allergen was likely eaten.

Medication/Doses:

Epinephrine (Brand/Dosage): ____

Antihistamine (Brand/Dosage): ____

Other (ex: inhaler-bronchodilator if asthma): ____

_____ Student may self-carry epinephrine _____ Student may self-administer epinephrine

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency services consistent with this plan, including the administration of medication to my child. I understand that the Local Government and Governmental Employees Tort Immunity Act protect staff members from liability arising from actions consistent with his plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: ____ Date: ____________

Licensed Healthcare Provider Signature: ___________________________________ Date: ____________