Food Allergy Action Plan

New Kent County Public Schools

Student's Photo

Name: _____ DOB: _____

Allergy to: _____

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

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 SYMPTONS after suspected or known ingestion:
One or more of the following:
LUNG: Short of breathe, 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

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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)

DOSAGE

Epinephrine: inject intramuscularly (check one)
☐ EpiPen®
☐ EpiPen® Jr.
☐ Twinject ® 03. Mg
☐ Twinject ® 0.15 mg

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.

PLEASE NOTE: A physician's order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.

INSTRUCTIONS FROM PHYSICIAN:

☐ I have instructed this student in the proper use of his/her emergency medication for anaphylaxis. This student should be able to carry and use this medication at school independently.

☐ This student needs assistance using his/her emergency medication for anaphylaxis in school.

Physician Signature Phone Number Date

PARENT PERMISSION:

By signing this form, I give permission for the school to use the above plan to manage my child's allergy. The school may contact my child's physician regarding their allergy. I understand that I may request to meet with the counselor to discuss educational accommodations that may be needed in the school setting.

Parent Signature Date RN Signature Date

CONTACTS:

Call 911

Doctor: _____ Telephone: _____

Parent/ Guardian: _____ Telephone: _____

Parent/ Guardian: _____ Telephone: _____

Other Emergency Contacts:

Name/ Relationship: _____ Telephone: _____

Name/ Relationship: _____ Telephone: _____

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 reoccur. 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.

Trained Staff Members:

1. _____ **2.** _____

3. _____ **4.** _____