EMERGENCY FOOD ALLERGY AND SEVERE ALLERGY ACTION PLAN

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Information (Please include recent photo)

Student Name _____ Age _____ DOB_____

School_____ Grade_____ Teacher_____

School Bus Rider (please check) _____ No or _____ Yes, and they ride bus number _____

Parent/Guardian Information

Name_____Phone_____ Relationship_____

Name_____Phone_____ Relationship_____

Healthcare Provider and Emergency Information

Physician/Provider Name_____ Phone_____

Preferred Local Hospital In Case of Emergency_____

LIST ANY SEVERE ALLERGY(IES) YOUR CHILD HAS:

Food: _____

**** A Food Substitution or Modification Form will need to be completed and kept on file in the cafeteria****

Insect: _____ Animal: _____

Pollens: _____ Other: _____

PLEASE CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK:

- ❑ Difficulty Breathing
- ❑ Difficulty in Swallowing
- ❑ Loss of Consciousness
- ❑ Rash
- ❑ Nausea
- ❑ Swelling : How much? _____ Where ? _____
- ❑ Flushed or unusually pale skin
- ❑ Other (List) _____

Has hospitalization been needed in the past year for allergies ? _____ NO _____ YES (If YES) When? _____

Are medications needed for the allergy (ies) ? _____ NO _____YES (List)_____

Notify Parent/Guardian in the following situations : _____

My signature allows permission to include my child's picture with this plan. I give permission for my child to administer, be administered or assisted in the self-administration of the epinephrine auto-injector by authorized persons. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider who signs the Medication Order Form regarding any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the epinephrine auto-injector. Any unused medication will be destroyed at the end of the current school year if not retrieved by parent/guardian. Nurses have no authority to treat and/or to provide oversight for medical conditions without signed provider order and parental consent. In the event of an emergency or medical necessity, 911 will be called.

Parent/Guardian Signature_____ **Date**_____

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TO BE COMPLETED BY HEALTHCARE PROVIDER:

Student Name_____ **Date of Birth**_____

ALLERGEN(S) TO AVOID_____

Student also has Asthma (Please check): ____ NO ____ YES ****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".

- ACTION FOR **MINOR** ALLERGIC REACTION

If minor symptoms (list):_____give antihistamine_____
(Please List Medication/dose/route)

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

- ACTION FOR **MAJOR** ALLERGIC REACTION

If ingestion is suspected and/or symptoms (list): _____

Give_____**IMMEDIATELY and CALL 911.**

(Please List Medication/Dose/Route)

It is my professional opinion that the above named student shall be allowed to carry his/her Epinephrine Auto-Injector (Please check) ____YES or ____NO

Healthcare Provider's Name_____

Healthcare Provider's Signature _____ **Date**_____

Address_____ **Phone**_____ **Fax**_____

(School Staff Only) Completed Form Received On _____ By _____

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A list of school personnel trained in medication administration for the current school year is available in the school clinic.

Epinephrine Auto-Injectors Locations and Expiration Dates:
Location 1: _____ Expiration Date: _____
Location 2. _____ Expiration Date: _____
Location 3. _____ Expiration Date: _____

It is MANDATORY that the location(s) of the student's epinephrine auto-injector(s) be given to the following school personnel along with signature of receipt. Locations of the epinephrine auto-injectors and IHP are filed in the following places:

Signatures	**Date**
Office staff _____	_____
Cafeteria manager _____	_____
Teacher _____	_____
Teacher _____	_____
Teacher _____	_____
Teacher_____	_____
Teacher _____	_____
Teacher _____	_____
Teacher_____	_____
School Nurse _____	_____

Nursing Assessment Describing Student's Competency to Carry and Administer epinephrine auto-injector, if applicable:
(Nurse must evaluate student twice annually, if student carries own epinephrine auto-injector)
Evaluation 1: _____ Date: _____Student Competent: Yes____ No_____
Nursing Comments: _____

Evaluation 2: _____ Date: _____Student Competent: Yes_____No_____
Nursing Comments: _____

Date of Annual Food Allergy Management Team Meeting:_____
Members/Title attending:_____
_____

Note: A copy of this form will accompany the student to the emergency room.

_____
Nurse Signature/Date