

Food Allergy Action Plan

Emergency Care Plan

Place
Student's
Picture
Here

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

Allergy to: _____

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

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, diarrhea, 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 _____

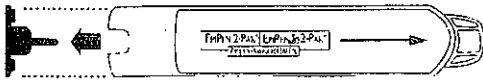
Date _____

TURN FORM OVER

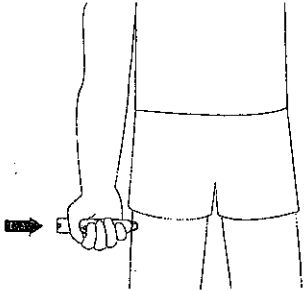
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)

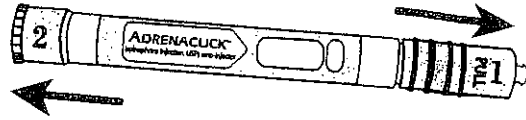


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove **GREY** caps labeled "1" and "2."



Place **RED** rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: () -) Doctor: _____
 Parent/Guardian: _____

Phone: () - _____
 Phone: () - _____

Other Emergency Contacts

Name/Relationship: _____
 Name/Relationship: _____

Phone: () - _____
 Phone: () - _____

Medical Plan of Care for School Food Service (Students with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name	Date of Birth	M	F
Name of School/Center/Program	Grade Level/Classroom		
Parent's/Guardian's Name	Address, City, State, Zip Code		
()	()		
Home Phone	Work Phone		

Part 2: Request for milk substitution for non-disabling special dietary needs only

School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.

School/school district provides _____ as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes No
List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

Medical Authority or Parent/Guardian Signature: _____ Date: _____

Part 3: To be completed by Physician/Medical Authority

Disability/Special Dietary Needs

Does the child have a **disability**? Yes No

If Yes,
Please describe the major life activities affected by the disability.

Does the child's disability affect their nutritional or feeding needs? Yes No

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes No
(*These accommodations are optional for schools to make)

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: To be completed by Physician/Medical Authority

Diet Order

List any dietary restrictions, such as food allergies, intolerances or restrictions:

List specific foods to be substituted (Substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number

Office Stamp

Physician/Medical Authority's Signature

Date

Part 5: Parent Signature

Date

Part 6: School Nutrition Program Signature

Date

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to

_____ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: _____ Date: _____
(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. _____ Date _____ Date _____ Date _____

_____ Date _____ Date _____ Date _____ Date _____ Date _____

A copy of this form should be kept by the School Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.