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.

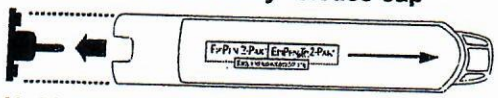
Parent/Guardian Signature _____ **Date** _____ **Physician/Healthcare Provider Signature** _____ **Date** _____

TURN FORM OVER

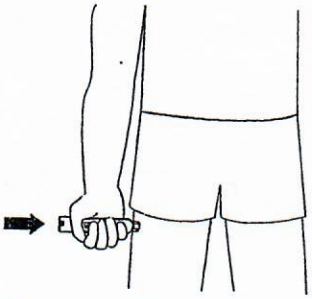
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

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

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

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

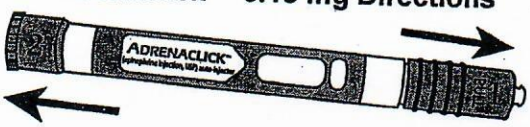
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

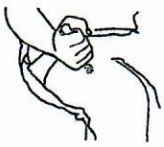
Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

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:_____ Phone: (___)_____-_____

Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___)_____-_____

Name/Relationship: _____ Phone: (___)_____-_____

Child Nutrition Medical Statement for Meal Modifications

Contact Information – to be completed by the school

Student's Name	
Age / Grade	
School Name	
School Address	
School District	
School Principal	
Phone	
Teacher	
Child Nutrition Manager	
Other Team Members	

Medical Statement – to be completed by a licensed physician or other healthcare professional with prescriptive authority in Arkansas

Patient's Name	
Dietary Restriction(s) *A brief explanation of the physical or mental impairment and how it affects the diet*	
Accommodation(s) Needed *May include, but is not limited to, food(s) to avoid or restrict, food(s) to substitute, caloric modifications, substitution of liquid nutritive formula, etc.*	

If additional information, including nutrition education materials shared with the family, is available and/or necessary, please attach to this form or send to the school's Child Nutrition Manager.

Date

Signature of Licensed Physician

INDIVIDUAL HEALTH CARE PLAN

Act 1565 (1999) amends Annotated Arkansas Code 6-18-1005 to require Individualized Health Care Plans for students with special health care needs in schools. **(This information is CONFIDENTIAL.)**

Student's Name _____ Date of Birth _____ Grade _____

School _____ Allergies _____

Student's Diagnosis _____

Brief History on medical condition _____

PROCEDURES AND INTERVENTIONS(TO BE COMPLETED BY PHYSICIAN OR CLINIC NURSE)

1. Does the student require assistance to attend school? _____ If YES, documentation in items 2-10 should support this requirement.

2. Health care treatments, medications, or procedures (i.e. blood sugars, caths) at school:
_____
_____

3. Health care treatments, medications, or procedures at home: _____
_____

4. Potential side-effects of medication(s) or treatment(s): _____

5. Transportation (bus, parent, etc.): _____

6. Suggested environmental modifications (seating in front of room, avoidance of specific allergens, etc.): _____
_____

7. List necessary equipment and supplies and person(s) responsible for providing these items:
_____
_____

8. Safety Measures: _____

9. Dietary requirements: (Certification of disability form must be completed for school to accommodate.): _____

10. Activity Limitations: _____

PLEASE ATTACH A COPY OF STUDENT'S MOST RECENT PHYSICAL EXAMINATION

Physician's Signature _____ **Date Signed** _____

Emergency Plan ( ) Attached ( ) Check if additional information is attached.