Place Child's Picture Here

HEALTH LINK LLC

Food Allergy Action Plan
Step 1: Prevention

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

ALLERGY TO: _____

_____

Asthmatic? Y/N) _____ (Yes=Higher Risk for Severe Reaction)

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to:_____
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific actions plans for emergency care
- ☐ Current, non-expired medications
- ☐ Provide safe snack option to school/classroom
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Make every effort to avoid contact with allergen
- ☐ Alert nearest adult if suspect exposure to allergen
- ☐ Other

Notes:

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Food Allergy Action Plan

HEALTH LINK LLC

Student's Name: _____ **Date of Birth:** _____
Teacher's Name: _____ **Room #:** _____
ALLERGY TO: _____

_____

Asthmatic? (Y/N) _____ (Yes=Higher Risk for Severe Reaction)

STEP 2: TREATMENT

Symptoms	**Give This Medication**	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but *no symptoms*		
Mouth: itching, tingling, or swelling of lips, tongue mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat *: Tightening of throat, hoarseness, hacking cough		
Lung*: Shortness of breath, repetitive coughing, wheezing		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

Administer:

____ **Epinephrine auto-injector 0.15 mg** ____ **Epinephrine auto-injector 0.3 mg**

____ **Repeat dose if EMS has not arrived in 10 minutes**

Antihistamine: give _____

Other: give _____

IMPORTANT: CALL 911 IMMEDIATELY

Asthma inhalers and/or antihistamines can not be depended on to treat anaphylaxis.

STEP 3: EMERGENCY CONTACTS

_____ **Parent's Name** _____ **Phone Number**

_____ **Secondary Emergency Contact** _____ **Phone Number**

_____ **Consulting School Nurse** _____ **Phone Number**

_____ **Parent Guardian's Signature/Date** _____ **Doctor's Signature/Date**