PHOTO IF AVAILABLE

Student Name_____
School/Teacher_____

FRANKLIN SPECIAL SCHOOL DISTRICT
FOOD ALLERGY ACTION PLAN

Student's Name:_____ **Date of Birth:**_____

ALLERGY TO:_____
This student cannot eat or handle this food, or any food containing this as an ingredient as there is a risk of anaphylaxis (extremely severe allergic reaction).

****

SECTION BELOW TO BE COMPLETED BY STUDENT'S PHYSICIAN

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STEP 1: PREVENTION: To prevent exposure, FSSD schools have a policy of no sharing of food at school. In addition, there is no food allowed on school buses. All schools can provide an allergy alert cafeteria table or zone, and an allergy alert classroom(s) where every effort is made to prevent exposure to the food allergen. Please indicate below if the student requires the above accommodations, or indicate if the parent can choose their preference for this child.

Student should be assigned to "Allergy Alert" lunch table/zone: ____ Yes ____ No ____ Parent/Guardian Choice

Student should have an "Allergy Alert" classroom: ____ Yes ____ No ____ Parent/Guardian Choice

STEP 2: TREATMENT

Administer medication if child has ingested or come in to contact with the above named food OR if ingestion is suspected and symptoms are observed.

Mouth: Itching, tingling, or swelling of lips, tongue, mouth:	____Epinephrine	____ Antihistamine
Throat: Itching, throat closing up, hoarseness, hacking cough:	____Epinephrine	____ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea:	____Epinephrine	____ Antihistamine
Lung: Shortness of breath, repetitive coughing, wheezing:	____Epinephrine	____ Antihistamine
Heart: Thready pulse, low blood pressure, fainting, pale, bluish discoloration	____Epinephrine	____ Antihistamine
Other:_____	____Epinephrine	____ Antihistamine
If reaction progressing or several of above areas affected:	____Epinephrine	____ Antihistamine

****The severity of symptoms can quickly change to potentially life threatening****

It is my opinion that this student _____ is_____ is NOT (check one) competent to possess an epinephrine auto-injector (if provided by the parent/guardian) to self-administer on school property or at school events according to this health care plan.

STEP 3: EMERGENCY CALLS
CALL 911 after epinephrine is administered. State that child is having an anaphylactic reaction and has received initial dose of epinephrine and additional may be needed.

MEDICATION DOSAGE:

Epinephrine:_____ **Inject intramuscularly per manufacturer instructions.**
Quantity Received: _____ Medication Expiration Date: _____
Possible Side Effects: _____

Antihistamine:_____**(medication, dose, route).**
Quantity Received: _____ Medication Expiration Date: _____
Possible Side Effects: _____

Additional Orders/Considerations: _____

Physician Name:_____ Phone:_____

Physician Signature:_____ Date:_____

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PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

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Student's Name: _____ Date of Birth: _____
Father's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Mother's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact if parent not available: _____
(Authorized to act in behalf of parents if we are unable to contact parent)

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Physician Name: _____ Phone: _____ Fax: _____
Please describe any previous reaction(s) and date of reaction that your child has had to this food. Describe symptoms and treatment that was required for the reaction(s).

_____

_____

_____

My child _____ will _____ will NOT (check one) possess an epinephrine auto-injector (provided by parent) to self-administer on school property or at school events according to this health care plan. I release FSSD or its employees from liability as a result of my child's failure to carry or administer the medication according to the physician orders in this individualized healthcare plan.

Epipen/Epipen Jr. provided by parent/guardian WILL be carried by child on Bus # _____.

- **EPINEPHRINE AUTO-INJECTORS ARE TO BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND AVAILABLE FOR THE STUDENT DURING SCHOOL AND ON FIELD TRIPS. IF STUDENT IS A BUS RIDER, ADDITIONAL AUTO-INJECTOR SHOULD BE PROVIDED FOR BUS TRANSPORTATION. IN THE EVENT THAT AN EPINEPHRINE AUTO-INJECTOR IS NOT AVAILABLE, 911 WILL BE CALLED.**
- **EXPIRED AUTO-INJECTORS MUST BE REPLACED. AN EXPIRED AUTO-INJECTOR CANNOT BE ADMINSTERED BY THE SCHOOL NURSE OR OTHER TRAINED ASSISTIVE PERSONNEL.**
- **MEDICATIONS MUST BE PICKED UP BY A PARENT/GUARDIAN AT THE END OF THE SCHOOL YEAR. MEDICATIONS NOT PICKED UP WILL BE DISPOSED OF ACCORDING TO STATE REGULATIONS.**

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SCHOOL NURSE TO COMPLETE THE SECTION BELOW

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The following staff are trained to administer Epinephrine for this student:

_____ Location in building: _____
_____ Location in building: _____
_____ Location in building: _____
Location in building of child's Epinephrine: _____

On field trips, Epinephrine will be with: _____

I understand that health information regarding my child will be kept confidential, but shared with school personnel on a need to know basis in order to protect the health and safety of my child. I release the Franklin Special School District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand that my child may be administered medication/procedures on field trips or in the absence of a school nurse by unlicensed, trained personnel (such as a teacher/school employee). I understand that my child will be administered medications and emergency treatment as indicated by the physician orders on other side of this form. This treatment will be administered even if a parent/guardian cannot be reached. The physician completing the other side of this form has permission to provide this and other information regarding my child's health needs to the school nurse, principal or designated assistive personnel. The school nurse has my permission to speak with my child's physician regarding this plan and related health issues to promote the health and safety of my child. I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called. I agree that this health plan meets the needs of my child.

Parent/Guardian Name	**Parent/Guardian Signature**	**Date**
Nurse Name	**Nurse Signature**	**Date**