

Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME: _____	DATE OF BIRTH: _____
SCHOOL: _____	GRADE: _____

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- | | |
|--|--|
| <input type="checkbox"/> Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
<input type="checkbox"/> General: panic, sudden fatigue, chills, fear of impending doom
<input type="checkbox"/> Mouth: itching, tingling, or swelling of the lips, tongue, or mouth | <input type="checkbox"/> Respiratory: shortness of breath, repetitive coughing, wheezing
<input type="checkbox"/> Skin: hives, itchy rash, swelling about face or extremities
<input type="checkbox"/> Throat: feeling tightness in the throat, hoarseness, hacking cough
<input type="checkbox"/> Other: _____ |
|--|--|

Treatment:

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation / CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:	Substitutions:	Foods to omit:	Substitutions:
<input type="checkbox"/> Eggs	_____	<input type="checkbox"/> Milk	_____
<input type="checkbox"/> Whole	_____	<input type="checkbox"/> Milk	_____
<input type="checkbox"/> Ingredient in Recipe	_____	<input type="checkbox"/> Cheese	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Whey	_____
<input type="checkbox"/> Wheat	_____	<input type="checkbox"/> Ingredient in Recipe	_____
<input type="checkbox"/> Gluten	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Trace Amount	_____	<input type="checkbox"/> Nuts	_____
<input type="checkbox"/> Ingredient in Recipe	_____	<input type="checkbox"/> Tree Nut	_____
<input type="checkbox"/> Soy	_____	<input type="checkbox"/> Peanut	_____
<input type="checkbox"/> Soy Lecithin	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Oil	_____	<input type="checkbox"/> Fish	_____
<input type="checkbox"/> Isolated Soy Protein	_____	<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Ingredient in Recipe	_____	<input type="checkbox"/> Other Not Included on List	_____
<input type="checkbox"/> Other	_____		

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____
 Asthma: (circle) YES NO _____

Response for reaction to all other allergens: Give prompt treatment if the student has any of the following symptoms:

Treatment:

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO APN PA Date: _____
 Healthcare Provider Name (signature): _____ Phone: _____

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: _____ Date: _____ Phone #: _____