# Food Allergy Action Plan

Place Child's Picture Here

**Student's Name:**_____ **D.O.B:**_____ **Teacher:**_____

**ALLERGY TO:**_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

| **Symptoms:** | | **Give Checked Medication**:** **(To be determined by physician authorizing treatment) |
|---|---|---|
| ▪ If a food allergen has been ingested, but *no symptoms*: | | ☐ Epinephrine ☐ Antihistamine |
| ▪ Mouth | Itching, tingling, or swelling of lips, tongue, mouth | ☐ Epinephrine ☐ Antihistamine |
| ▪ Skin | Hives, itchy rash, swelling of the face or extremities | ☐ Epinephrine ☐ Antihistamine |
| ▪ Gut | Nausea, abdominal cramps, vomiting, diarrhea | ☐ Epinephrine ☐ Antihistamine |
| ▪ Throat† | Tightening of throat, hoarseness, hacking cough | ☐ Epinephrine ☐ Antihistamine |
| ▪ Lung† | Shortness of breath, repetitive coughing, wheezing | ☐ Epinephrine ☐ Antihistamine |
| ▪ Heart† | Weak or thready pulse, low blood pressure, fainting, pale, blueness | ☐ Epinephrine ☐ Antihistamine |
| ▪ Other† | _____ | ☐ Epinephrine ☐ Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give: | | ☐ Epinephrine ☐ Antihistamine |

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

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

**Antihistamine:** give_____
medication/dose/route

**Other:** give_____
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

| Name/Relationship | Phone Number(s) | |
|---|---|---|
| a. _____ | 1.)_____ | 2.) _____ |
| b. _____ | 1.)_____ | 2.) _____ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

# School Medication Administration Authorization Form

This order is valid only for school year (current)_____, including summer session.

School:_____

This form must be completed fully in order for school to administer the required medication.
A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- ★ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ★ Non-prescription (over the counter) medication must be in the original container with the label intact. Students' names and date of birth must be on the medication.
- ★ Over the counter medications, except topical creams/ointments, require physician signature.
- ★ An adult must bring the medication to school. Any controlled substance must be counted with the parent and a staff member.
- ★ If a controlled substance is permitted for self carry, only the daily dose(s) needed are allowed to be carried.

## Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade:_____

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____ Route:_____

Time/frequency of administration:_____ If PRN(as needed), frequency:_____

If PRN(as needed), for what symptoms: _____

Special administration instructions:_____

Relevant side effects: ▫ None Expected ▫ Specify:_____

Special storage requirements: ▫ None ▫ Refrigerate ▫ Other:_____

Medication Shall be administered from:(Month/day/year):_____ to _____

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

**Prescriber's Signature**:_____

Date:_____

## Parent/Guardian Authorization

I/We request school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication. I/We authorize the school personnel to communicate with the health care provider as allowed by HIPAA.

**Parent/Guardian Signature**:_____ Date:_____

Home/Cell Phone #:_____ Work Phone #:_____

## Self Carry/Self Administration of Medication Authorization/Approval

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and parent.

This student may carry this medication: ▫ Yes ▫ No

This student is both capable and responsible for self-administering this medication:

▫ Yes, supervised ▫ Yes, unsupervised ▫ No

**Prescriber's authorization for self carry/self administration of medication**: _____
Signature/Date

**Parent's approval for self carry/self administration of medication**:_____
Signature/Date

MICHIGAN Department of Education

Michigan Department of Education
Office of Health and Nutrition Services

## MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant. See back side for instructions.

| 1. School/Agency Name: | 2. Site Name: | 3. Site Telephone: |
|---|---|---|
| 4. Name of Participant/Student: | | 5. Participant Age: |
| 6. Name of Parent/Guardian: | | 7. Parent/Guardian Telephone: |

**8. Check One:**

☐Participant has a disability and *requires* a special meal or accommodation (Refer to Instructions on reverse side of this form). Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to religious, cultural, economic, or other preferences. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests but are not required to do so. Any meals provided must fully meet the meal pattern. **A school administrator or parent/guardian may sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), nurse, school administrator, or parent/guardian may sign this form.**

**9. Disability or medical condition requiring a special meal or accommodation:**

**10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:**

**11. Diet prescription and/or accommodation:** (*please describe in detail to ensure proper implementation- use extra pages as needed; see instructions on reverse side*)

**12. Specific foods to be omitted and substitutions:** (*please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed; see reverse side*)

**A. Food(s) To Be Omitted:** **B. Suggested Substitution(s)**

_____

_____

**13. Indicate Texture:**

☐Regular ☐Chopped ☐Ground ☐Pureed

**14. Adaptive Equipment Needed (if applicable):**

| 15. Signature of Parent/Guardian: | 16. Printed Name: | 17. Telephone: | 18. Date |
|---|---|---|---|
| 19. Signature of Medical Authority (if applicable): | 20. Printed Name: (include credentials and license/registration number) | 21. Telephone | 22. Date |

This institution is an equal opportunity provider.

Revised 9/2018

LHSA
*A Community Action Agency*

EARLY HEAD START/HEAD START
ALLERGY/PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent/Guardian:

You have indicated on your child's emergency card or health history that your child has allergies. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child's allergies? Yes ____ No ____

2. Which of the following is your child allergic to? Please list.
   Foods _____
   Environmental (trees, pollen, etc.) _____
   Animals _____
   Medications _____
   Other _____

3. What happens to your child during an allergic reaction? _____
   _____

4. Does your child need special care during an allergic reaction? Yes ____ No ____
   If yes, what care does your child need? _____

5. Is your child currently taking medications for allergies? Yes ____ No ____
   If yes, please list all medications. _____

6. Does your child need medication at school for treatment of allergies? Yes ___ No ___

****If your child needs medical attention or medication for an allergic reaction while at school, you and your child's physician must complete and sign an ALLERGY ACTION PLAN.**

7. Is there anything else we need to know about your child's allergies? _____
   _____

8. Parent/Guardian Signature _____Date: _____

Thank you for your cooperation.

_____ _____ _____
Head Start/Early Head Start Staff Phone # Date

Revised 2/18

OLHSA

*A Community Action Agency*

OLHSA EARLY HEAD START/HEAD START
Medication Parent Consent Form

All prescription medicine must be in the original pharmacy container, clearly labeled with the child's name, physician's name, date and instructions for administering medication. To protect your child and others, please **do not leave** any medication in your child's belongings, cubby, locker or classroom. Medication must be personally delivered to a Head Start/Early Head Start staff member.

I agree to hold OLHSA Head Start/Early Head Start and its staff free from any liability in the event of allergic reaction or mishap occurring as a result of medication being administered to my child at my request and according to the instructions provided by a physician, at the center or field trip.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____