Food Allergy Action Plan

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†	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

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

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: ________________at_______________

3. Parents________________________ Phone Number(s)____________________________

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. ____________________	1.)______________	2.) ______________
b. ____________________	1.)______________	2.) ______________

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

Parent/Guardian Signature______________________________ Date____________

Doctor's Signature______________________________ Date____________
(Required)

Emergency Contact Numbers:		
Parent/Guardian: a. b.	Home phone: Work: Cell: Work: Cell:	
Emergency contact: relationship:		Phone:
Primary Care Physician:		Phone:
School Nurse:		Phone: Fax:

Other health concerns:	
Other Medications:	Dose/Time:
Dietary concerns/restrictions:	
Parent Signature	Date:

Individual Considerations:

Bus-Transportation should be alerted to student's allergy

- This student carries Epinephrine on the bus ☐ YES ☐ NO
- Epinephrine can be found in: ☐ Backpack ☐ On person ☐ Other: (specify)__________
- Student will sit at front of bus ☐ YES ☐ NO
- Other (specify): ______________________________

Field Trip Procedures: Epinephrine should accompany student during any off campus activities (caution with bee sting allergies).

- The student should remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No
- Staff members on trip must be trained regarding auto-injector use and health care plan (plan must be taken with).
- Other (specify): ______________________________

Classroom: This student is allowed to eat only the following foods:

☐ Those in manufacturer's packaging with ingredients listed and determine allergen free by the parent/nurse
or: ______________________________

☐ Those approved by parent.

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.

☐ Classroom projects should be reviewed by teaching staff to avoid specific allergens.

☐ Other (specify): ______________________________

☐ Middle school or high school student will be making his/her own decision.

☐ Middle or High School teachers will be informed of Life Threatening Food Allergy.*

☐ Substitute Folder and Specialists informed of Life Threatening Food Allergy.

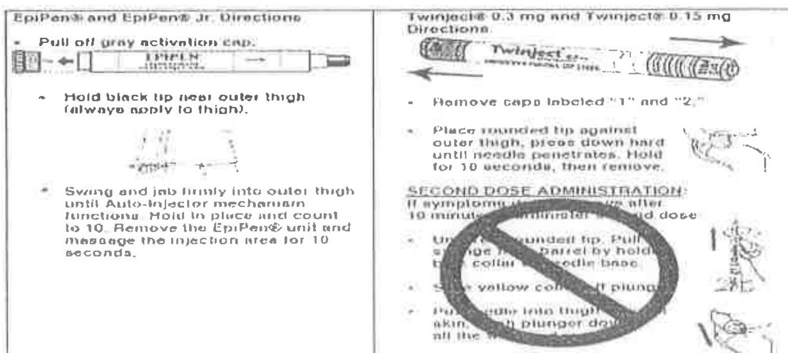
Cafeteria: ☐ **NO Restrictions**

☐ Student will sit at a specified allergy table.

☐ Student will sit at the classroom table at a specified location.

☐ Specified table will be cleaned according to procedure guidelines.

- Nutrition services staff should be alerted to the student's allergy.
- Health Care Plan posted in cafeteria in a private place ☐ Yes ☐ No



EpiPen®/Epinephrine can only be given if you have been trained to use it.

MOLINE SCHOOL DISTRICT #40
ALLERGY HEALTH CARE PLAN

Name:	
Regular HCP ☐ 504 HCP ☐	Date:
Birth Date:	Student #:
School:	Grade:
Asthmatic? yes*☐ no ☐ *if yes, increased risk for severe reaction.	
Severe Allergy to:	

If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911 Allergy Symptoms:

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  - **NOTE TIME_________AM/PM (Epinephrine given)** ◆ **NOTE TIME__________AM/PM (Antihistamine given)**
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epinephrine is administered.**
- **DO NOT HESITATE to administer Epinephrine and to call 911, even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and Epinephrine is being administered.
- An adult trained in CPR is to stay with student–monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at______________.
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - Notify the administrator and parent/guardian.
  - Dispose of used auto-injector in "sharps" container or give to EMS along with a copy of the Care Plan.

MEDICATION ORDERS

EpiPen® (0.3) ☐ EpiPen Jr.® (0.15) ☐ Other: _____	Side Effects:
Repeat dose of EpiPen®: ☐ Yes ☐ No	If YES, when
Antihistamine: ____________ cc/mg	Give: _____ Teaspoons _____ Tablets by mouth Side Effects:

- It is medically necessary for this student to carry an Epipen® during school hours. ☐ Yes ☐ No
- Student may self-administer Epipen®. ☐ Yes ☐ No
- Student has demonstrated use to LHCP. ☐ Yes ☐ No

Licensed Health Care Provider's Signature:	Date:	
Licensed Health Care Provider's Printed Name:	Phone:	Fax Number:

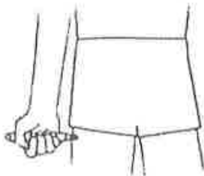
TRAINED STAFF MEMBERS

1. ______________________________ Room ________
2. ______________________________ Room ________
3. ______________________________ Room ________

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.

- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

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

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

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

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Food Allergy Action Plan

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Name/Relationship | Phone Number(s)

a. ______________________________ 1.)____________________ 2.)____________________

b. ______________________________ 1.)____________________ 2.)____________________

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

Parent/Guardian Signature______________________________ Date____________

Doctor's Signature______________________________ Date____________
(Required)

Emergency Contact Numbers:		
Parent/Guardian: a. b.	Home phone: Work: Cell: Work: Cell:	
Emergency contact: relationship:		Phone:
Primary Care Physician:		Phone:
School Nurse:		Phone: Fax:

Other health concerns:	
Other Medications:	Dose/Time:
Dietary concerns/restrictions:	
Parent Signature	Date:

Individual Considerations:

Bus-Transportation should be alerted to student's allergy

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- Student will sit at front of bus ☐ YES ☐ NO
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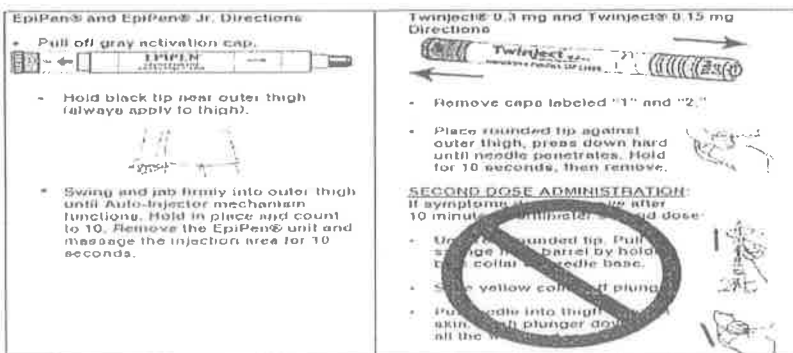
- Health Care Plan posted in cafeteria in a private place ☐ Yes ☐ No



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MOLINE SCHOOL DISTRICT #40
EMERGENCY HEALTH CARE PLAN

Name:		
Regular HCP ☐ 504 HCP ☐	Date:	
School:	Grade:	
Teacher:	Birth Date:	
Health Concerns/Diagnosis:		

Allergies:	
Medications:	**Dose/Time:**
Emotional/behavioral concerns:	
Dietary concerns/restrictions:	
Health Action Plan:	

4-11

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Moline School District #40

SEIZURE ACTION PLAN

Effective Date________

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:________________________________ Date of Birth:__________

Parent/Guardian:______________________________ Phone: ____________ Cell:______________

Treating Physician:____________________________ Phone: ____________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:____

Student's reaction to seizure:____

BASIC FIRST AID: CARE & COMFORT:

(Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at ______________________________
- ☐ Call 911 for transport to ______________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other______________________________________

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, etc.)

Physician Signature:________________________________ **Date:**__________

Parent Signature:__________________________________ **Date:**__________

Parent Signature:	Date:
MD Signature (if necessary):	
Contact Information:	
Parent/Guardian: 1. ____________ 2 ____________	Home phone: Work: ____________ Cell: ____________ Work: ____________ Cell: ____________
Home Address #1:	Home Address #2:
Emergency contact:	Phone:
Primary Care Physician:	Phone:
Specialty MD:	Phone:
School Nurse:	Phone:

Copies:

- ☐ Parent
- ☐ Teacher 1st___ 2nd___ 3rd___ 4th___ 5th___ 6th___ 7th___
- ☐ PE
- ☐ Library
- ☐ Music
- ☐ Recess
- ☐ Transportation
- ☐ Clinic

Moline School District

Date of Plan: ___________

Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with the relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: ____

Student's Name: ____

Date of Birth: ______________________ Date of Diabetes Diagnosis: ________________

Grade: ____________________________ Homeroom Teacher: ______________________

Physical Condition: ☐ Diabetes Type 1 ☐ Diabetes Type 2

Contact Information

Guardian(s): ____

Address:

____

Telephone: home ________________ cell __________________ work ________________

Student's Health Care Provider Information

Physician/Endocrinologist: ____

Address:

____

Telephone: ____________________________ /

____

Other Emergency Contacts

Name: __________________________________ Relationship: ______________________

Telephone: home __________________ cell ________________ work __________________

Notify guardian/emergency contact in the following situations: ______________________

____

_

____

_

____

_

Blood Glucose Monitoring:

Type of meter student is using to perform blood glucose checks

____

Can student perform their own blood glucose checks?__________ ☐☐

Exceptions:

____

Target Range for blood glucose: ______________________

Blood Glucose Levels should be checked at school:

- ☐ Before Exercise
- ☐ After exercise
- ☐ Before Lunch/Snacks
- ☐ When student exhibits symptoms of hypo/hyperglycemia
- ☐ Other: ____

  ____

  _

Insulin

Type of insulin student will be using at school: _____________________________

Usual Lunchtime DoseBase dose of insulin at lunch is _______units or does flexible dosing using _______units/______grams carbohydrate.

Insulin Correction Doses

Parental authorizations should be obtained before administering a correction dose for high blood glucose levels. ☐YES ☐NO

Insulin to carb ratio ______:______

Correction Factor ____

Correction Scale:

_______ units if blood glucose is _______to _______mg/dl

_______ units if blood glucose is _______to _______mg/dl

_______ units if blood glucose is _______to _______mg/dl

_______ units if blood glucose is _______to _______mg/dl

Can student give their own injections? ☐YES ☐NO

Can student determine the correct amount of insulin? ☐YES ☐NO

Can student draw the correct dose of insulin? ☐YES ☐NO

For Students with INsulin Pumps

Type of

Pump:____

Type of Insulin in Pump:

____

Basal Rate___________and time _____________

Basal Rate___________and time _____________

Basal Rate___________and time _____________

Student Pump abilities/Can student:

Count carbohydrates ☐YES ☐NO

Bolus correct amount for carbohydrates consumed ☐YES ☐NO

Calculate and administer corrective bolus ☐YES ☐NO

Calculate and set Basal Profiles ☐YES ☐NO

Calculate and set temporary basal rate ☐YES ☐NO

Disconnect pump ☐YES ☐NO

Reconnect pump at infusion set ☐YES ☐NO

Prepare reservoir and tubing ☐YES ☐NO

Troubleshoot alarms and malfunctions ☐YES ☐NO

For Students Taking Oral Diabetes Medications

Type of medication:_____________________________ Time

Taken:______________________

Type of medication:______________________________ Time Taken:______________________

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐YES ☐NO

Does your student have a food allergy or foods you feel should be avoided? (Please specify)

____

_

Meal/Snack	Time	Carb Amount
Breakfast:	____________	____________
Mid-morning snack:	____________	____________
Lunch:	____________	____________
Mid-afternoon snack:	____________	____________
Dinner:	____________	____________

Other times student should have snack, such as before or after excercise: _______________

____

Instructions for when food is provided to the class (e.g., as part of a class party, food sampling, etc.)____

____

_

Exercise and Sports

Restrictions on activity, if any: ____

Student should not exercise if blood glucose level is **below**__________,or **above**__________, or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual Symptoms student:

____

____

Treatment of hypoglycemia:

____

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.

Route ____________ Dasage_____________ Site_______________

If glucagon is required, administer it promptly. Then call 911 followed by the parents/guardians.

Hyperglycemia (High Blood Sugar)

Usual symptoms for student: ____

____

Treatment of hyperglycemia: ____

____

Urine should be checked for ketones when blood glucose levels are above __________mg/dl

Treatment for ketones: ____

____

The following supplies should be provided by parent/guardian and kept in the school clinic for student use:

_______ Completed care plan signed by physician and guardian

_______ Medication administration forms for insulin and glucagon signed by physician and guardian.

_______Blood glucose meter, blood glucose test strips, batteries for meters

_______Lancet device and lancets

_______Urine ketone strips

_______ Insulin pump supplies (e.g. sites, tubing, etc.)

_______Insulin pen, pen needles, insulin cartridges

______Fast-acting source of glucose (e.g. juice, glucose tabs)

______Insulin

______Glucagon

This Diabetes Medical Management Plan has been reviewed and approved by:

______________________________________ ______________

Physician Signature Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of ______________________________School to perform and carry out the diabetes care tasks as outline by ____________________________'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know the information to maintain my child's health and safety.

Acknowledged and received by:

______________________________________ ______________

Student's Parent/Guardian Date

______________________________________ ______________

Student's Parent/Guardian Date