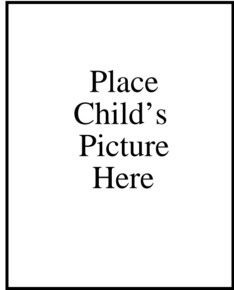
Food Allergy Action Plan



Student's Name:_______________________________**D.O.B:**___________**Teacher:**___________________

ALLERGY TO:____

<u>Asthmatic</u> Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

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

**To be determined by physician authorizing treatment

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

◆ 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. ______________________________ at ______________________________

3. Emergency contacts:

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

EVEN 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)

SPECIAL DIET ORDER FORM

Physician's statement for GODLEY ISD student with special dietary needs
Please fax to 817-389-3242 or mail form to: Godley ISD Foodservice Dept., 313 N. Pearson, Godley, TX 76044

Part 1 - to be completed by Parent/Guardian	Student's ID #_______________Birthdate_________________
Student's Last Name:___________________________________	Student's First Name:___________________________
Today's Date________________Student's Grade__________	Campus:____
Parent/Guardian Name:_______________________________	Parent Phone:___________________________________
	Mailing Address:_________________________________
Parent/Guardian Signature	

Part 2 - to be completed by licensed Physician	Name of disability or medical condition:__________________
Does the student have a Disability* that effects a major life activity?** Circle one: **YES** **NO**	
Is it considered immediately Life-Threatening? **YES** **NO**	How it affects a major life activity:____________________
For Allergy, is it by: (Check all that apply)	
Contact________Ingestion________Inhalation_______	Specify Feeding Equipment:___________________________
Explain why the Disability restricts the child's diet:	
	Specify Formulas:_________________________________

FOODS TO BE OMITTED:______________________________	**Diabetes: Type 1_________ Type II_________**
	Grams of Carbs at Breakfast:___________Lunch:___________
	Foods to be Substituted:____________________________

Texture Modification Needed:	Liquid Consistency Modification Needed:
Pureed______Ground_______Chopped_______Other_______	Regular______Nectar______Honey______Pudding______
Other Instructions:_____________________________________	
	Physician's Printed Name & Address:_____________________________

Physician's Signature:	Physician's Telephone Number:	Date:

Food Service Use Only

Date received at FS office:______________________ Date sent to FS Manager:________________________

*Definition of Disability per Rehabilitation Act of 1973 and Americans with Disabilities Act 1990: a physical or mental impairment that substantially limits one or more major life activities. Examples of physical or mental impairments include: orthopedic, visual, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, metabolic diseases such as diabetes and PKU, food anaphylaxis (severe food allergy), mental retardation, emotional illness, specific learning disabilities, human immunodeficiency disease and tuberculosis. Definition of "disability" under part B of the Individuals with Disabilities Education Actdelineates 13 disability categories:
such as: asthma, diabetes, nephritis, sickle cell anemia, heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, TB, emotional disturbance, specific learning disabilities, traumatic brain injury, visual impairment, including blindness, and multiple disabilities
**Major life activities covered by this definition include: caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. (Determinations for other special dietary needs, such as food intolerances and non-life threatening allergies will be considered on a case-by-case basis..)