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†	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. _________________________________ 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)

DOCUMENTATION OF AN ANAPHYLACTIC INCIDENT

The new law (NJSA 18A: 40-12.5) mandates that the use of an Epi Pen as a first treatment must be based on previously documented anaphylactic incident.

Student's Name ______________________ **DOB** ____________ **Grade** ________

Reviewed By ______________________ RN **School** ____________

TO BE COMPLETED BY PHYSICIAN

______________________ has had an anaphylactic incident:

- ☐ from a sting by ______________________ Date ____________
- ☐ after ingesting ______________________ Date ____________
- ☐ after exposure to ______________________ Date ____________

SYMPTOMS of the student's anaphylactic reaction included:

- ☐ hives spreading over the body
- ☐ wheezing
- ☐ difficulty swallowing / breathing
- ☐ swelling of lips, face, or neck
- ☐ tingling and swelling of tongue
- ☐ nausea / vomiting
- ☐ signs of shock (extreme pallor of flushing; clammy skin; rapid, weak pulse)
- ☐ loss of consciousness
- ☐ Other

____

____

MEDICATION given at the time of the incident:

☐ Epi Pen ☐ Epi Pen Jr. ☐ other form of adrenaline: ____________

____

☐ Epi Pen has been prescribed for precautionary purposes.

COMMENTS

____

____

Physician ______________________

Date ______________________ **Telephone** ____________

I. DOCTOR'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE.
TO BE FILLED OUT BY PHYSICIAN

The following medication is to be administered to my patient. ______________________________

MEDICATION ______________________ DOSE AND ROUTE ______________________

TIME GIVEN ______________________ DIAGNOSIS ______________________

SIGNIFICANT SIDE EFFECTS ____

LENGTH OF TREATMENT ____________ ______________________________
M.D. Signature

____
Print M.D. Name

II. DOCTOR'S REQUEST / INSTRUCTIONS FOR STUDENT SELF-ADMINISTRATION OF MEDICATION FOR A POTENTIALLY LIFE THREATENING ILLNESS.

TO BE FILLED OUT BY PHYSICIAN

The following medication is to be self-administered by my patient, ____________________________.
I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been Instructed in the proper administration of the required medication.

MEDICATION ______________________ DOSE AND ROUTE ______________________

TIME GIVEN ______________________ DIAGNOSIS ______________________

LENGTH OF TREATMENT ______________

SIGNIFICANT SIDE EFFECTS ____

______________________ ______________________________
Date M.D. Signature

____
Print M.D. Name

III. PARENT REQUEST AND RELEASE **TO BE COMPLETED BY PARENT/GUARDIAN**

I request my child, ______________________to (receive) (self-administer) the medication designated above. I have been informed by the school district that the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the **TENAFLY BOARD OF EDUCATION,** its agents, servants, and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medicine by my child.

______________________________ ______________________________
Date Signature of Parent/Guardian