Food Allergy Action Plan

Emergency Care Plan

(This form must be updated yearly)

Place Student's Picture Here

Name: _____D.O.B.: __/__/____

Allergy to: _____

Weight: _____lb. Asthma: ☐ Yes (Higher Risk for Severe Reaction) ☐ No

Extremely reactive to the following foods: _____

_____

Therefore:

___ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

___ If checked, give epinephrine immediately if the allergen was definitely eaten, even if No Symptoms are noted..

Any SEVERE SYMPTOMS after suspected or known Ingestion:

One or more of the following:

- Lung: Short of breath, wheeze, repetitive cough
- Heart: Pale, blue, faint, weak pulse, dizzy, Confused.
- Throat: Tight, hoarse, trouble breathing/swallowing
- Mouth: Obstructive swelling (tongue and/or lips)
- Skin: Many hives over body.

Or combination of symptoms from different body areas:

- Skin: Hives, itchy rashs, swelling (I.g eyes & lips)
- Gut: Vomiting, diarrhea, crampy pain.

1. **INJECT EPINEPHRINE IMMEDIATELY!**
2. **Call 911**
3. Begin Monitoring (see box Below)
4. Give additional medications*
   -Antihistamines
   -Inhaler (bronchodilator) If Asthma.

Mild Symptoms Only:

- Mouth: Itchy Mouth
- Skin: A few hives around mouth/face, mild itch
- Gut: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert health care professionals & parent
3. If symptoms progress see above.
4. Begin Monitoring (see below)

Medications / Doses

Epinephrine (brand & dose):_____

Antihistamine (name & dose)_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

Monitoring:

Stay with student; alert health care professionals and parent. Tell rescue squad that epinephrine was given and at what time.A second dose can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

_____ _____ _____ _____

Physician Signature: Date Parent/Guardian Signature Date

Glendale Elementary School District
Medical / Special Diet Request Form

Child's Name: _____ Date of Birth: _____ School: _____

Parent's Name: _____ Phone #: _____

Diagnosis related to diet Modifications: _____

Major life activity affected: _____

IMPORTANT NOTE: WE CANNOT ACCEPT AN ALLERGY LAB REPORT IN PLACE OF A PHYSICIAN'S NOTE.
If this is a dietary prescription for a child with disabilities, it must be signed by a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO). For special dietary needs for a child without disabilities, it must be signed by a Medical Authority, which also includes a naturopathic physician, Physician's assistant, or nurse practitioner.

If this is for **lactose intolerance only,** parent/guardian may disregard the physician/medical authority signature and sign here.

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

Foods to be omitted from child's diet:

_____ _____
_____ _____
_____ _____

Foods to be substituted:

_____ _____
_____ _____
_____ _____

Special Considerations:

_____ _____
_____ _____

Please Check:
___ Life Threatening (critical, needs close supervision)
___ Managed by child with moderate supervision
___ Self- controlled by child

Physician's Name (Print) _____ Signature _____
OR
Medical Authority Name (Print) _____ Signature _____

Phone: __(___)_____Date: _____

☐ I have read and agree with the above information provided by my health care provider;

Parent/Guardian Signature: _____ Date: _____