



CANUTILLO INDEPENDENT SCHOOL DISTRICT
Food Allergy Action Plan / Nutritional Medical Statement
 (To be renewed every school year)

Student ID# _____

Child's Name: _____ DOB: _____ School _____

Telephone#: _____ Teacher/Grade _____

ALLERGIC TO:

Asthmatic: *Yes No *High Risk for Severe Reaction

Diagnosis: (Include description of student's medical or other special dietary needs that restrict the child's diet)

List food(s) to be omitted from diet:

List food(s) that may be substituted with available CISD Food Service items.

Length of time diet will be required: _____

Any specialty food items requested and or required must be provided by Parent / Guardian.

Signs/Symptoms of An Allergic Reaction

- Mouth** Itching & swelling of lips, tongue or mouth, drooling.
- *Throat** Itching and/or a sense of tightness in throat, hoarseness, hacking cough, choking.
- Skin** Hives, itchy rash, and/or swelling of face or extremities, flushed face
- Abdomen** Nausea, abdominal cramps, vomiting and/or diarrhea
- *Lung** Shortness of breath, repetitive coughing, and/or wheezing, stridor
- *Heart** "Thready" pulse, "passing out"

The severity of symptoms can quickly change. ***Above symptoms can potentially progress to a life threatening situation. DO NOT hesitate to call 911**

HEALTH ACTION PLAN

<u>Actions for MINOR reaction</u>	<u>Actions for MAJOR reaction</u>

Emergency Contacts	Trained Staff Members
1. _____ / _____ Name/relation Phone	1. _____ Rm. _____
2. _____ / _____ Name/relation Phone	2. _____ Rm. _____
3. _____ / _____ Name/relation Phone	3. _____ Rm. _____

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child.

Parent/Guardian Signature

Date

Physician Signature/Printed and/or Stamped


Date

School Nurse Signature / Date


Cafeteria Manager Signature / Date

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray safety cap



2. Place black tip on outer thigh (always apply to thigh)



3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.

Parent authorizes copies of this document to:

- Parent
 Teacher
 P.E.
 Library
 Music
 Transportation
 Nurse
 Cafeteria

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