

STUDENT SERVICES



OCEANSIDE UNIFIED SCHOOL DISTRICT
2080 Mission Avenue • Oceanside CA 92058 • (760) 966-7802

FOOD ALLERGY INFORMATION

Student _____ Date _____

School _____ Grade _____ Room _____

Dear Parent/Guardian:

You noted in the health history that your child has an allergy to _____

► If eaten does this student have:

1. Difficulty breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Swelling of tongue or lips?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Rash or many hives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Nausea and vomiting ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is medication to be dispensed at school ? Yes No

Name of medication

Dosage

IF MEDICATION IS TO BE DISPENSED AT SCHOOL, YOU MUST SEND MEDICATION AND MEDICATION PERMISSION FORM TO THE SCHOOL HEALTH OFFICE

► Please return as soon as possible.

Sincerely,

School Nurse

Parent Signature

Date

Enclosed: FOOD ALLERGY ACTION PLAN
MEDICATION TAKEN BY STUDENT HS-22



Food Allergy Action Plan

Name: _____ D.O.B.: ____/____/____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

Place
Student's
Picture
Here

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 rashes, swelling (e.g., eyes, lips)
 GUT: Vomiting, crampy pain



- 1. INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 -Antihistamine
 -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

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 healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine 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. See back/attached for auto-injection technique.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

Date _____

TURN FORM OVER