

Food Allergy Action Plan

Student's Name: _____ D.O.B.: _____ Teacher: _____

Place
Child's
Picture
Here

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 <i>no symptoms</i> :	☐ 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† Weak or 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

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

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. _____ Phone Number: _____

3. Parent _____ Phone Number(s) _____

4. Emergency contacts:
Name/Relationship Phone Number(s)

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ (Required) Date _____

COLTS NECK TOWNSHIP SCHOOLS

Colts Neck, New Jersey

Administration of Epinephrine

This correspondence will serve as acknowledgement of the need for the administration of epinephrine to your child _____

Child's full name (print)

in case of emergency and of your request that the school personnel, including the nurse and other designated school employees administer epinephrine to your child in case of emergency.

This correspondence will further serve as notification to you pursuant to NJSA 18A:40-12.5 and NJSA 18A:40-12.6, that if the procedures specified in the aforementioned statutes are followed, the Colts Neck Township Schools and its employees shall have no liability for injuries arising from the administration of epinephrine to your child and that you agree to indemnify and hold harmless the school and the school district from all claims arising from the administration of epinephrine by school personnel to your child.

I agree to immediately contact the school nurse if any changes occur to this order and/or my child's condition changes. I agree to replace the EpiPen immediately if it is used or reaches its expiration date.

Acknowledged and Agreed

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date

Colts Neck Township Schools
Food Allergy Form

Student's Name _____

Homeroom Teacher _____

Dear Parents,

Please list any dietary restrictions or food allergies that your child has:

If your child has a food allergy, please complete the following:

How long has your child had a food allergy? _____

How many reactions has your child had? _____

What symptoms did your child experience during a reaction? _____

Has your child ever been treated with Benadryl or an EpiPen for an allergic reaction? _____

If yes please explain. _____

Please check one of the following options if your child has a nut allergy:

_____ I do not want my child to sit at a nut-free table

_____ I would like my child to sit at a nut-free table. I understand that my child may not bring **ANY** type of nut products in his/her lunch while seated at this table. In order to maintain the safety of the nut-free table visitors from other tables will not be permitted to sit at this table.

By signing below, I acknowledge that my child will sit at a nut-free table for the duration of the school year unless a request is made in writing to revoke this seating arrangement and that my child is also aware of this arrangement.

While the school will do its best to keep this table nut-free, I do understand that no area can be guaranteed to be completely nut-free at all times. I understand that I will encourage my child to not share food with others and to alert a staff member if feeling unwell. By signing this form, I am releasing the district from any liability that may arise from accidental exposure to an allergen.

Your child's safety is of the utmost importance to us. It is important to note that all Pomptonian cafeterias are nut allergy safe. Allergy-Aware menus are available for students with food allergies. For more information please contact Cheryl Pezzuti, Food Service Director at 732-946-0055 ext 4754.

I give permission for this information to be shared with Colts Neck Township employees and the class parents in my child's homeroom

Parent/Guardian Signature _____

Date _____