NORTH MERRICK UNION FREE SCHOOL DISTRICT
NORTH MERRICK, NY 11566

NORTH MERRICK
UNION FREE SCHOOL DISTRICT
– Nurturing Young Minds –

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a 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 rashes, swelling (e.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:*
   -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 Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

Student Allergy Checklist

Student Name:_____ DOB:_____

Teacher/Grade:_____

Identified Allergen:_____

Initial all that apply:

_____my child reacts with ingestion of allergen

_____my child reacts with touch of allergen

_____my child reacts with smell of allergen

_____my child is aware that sharing of food is not permitted

_____my child can purchase lunch in the school lunch room. I am aware that it is my responsibility to consult with the cafeteria manager regarding the ingredients of the foods served.

_____my child cannot purchase lunch in the school lunch room. I will provide lunch daily.

_____I will provide a "safe" snack for my child

_____my child cannot have any food or snacks brought in from outside sources.

_____my child will be allowed food or snacks brought in from outside sources. It is my responsibility to discuss this with the classroom teacher and class parent and approve the foods my child is allowed to have in writing.

_____Dunkin Donuts are/ are not O.K.

_____

_____

_____

I authorize my permission to have my child's medication taken on field trips and to be administered, if necessary, by the classroom teacher or other designated person in the absence of the school nurse. I also give my permission to share this information with the appropriate school staff. This plan is in effect for the current school year and summer session as needed.

Parent/Guardian Signature:_____Date:_____

A Release of Information /Good Samaritan Release Form

North Merrick Union Free School District
North Merrick, New York 11566

I, _____, the undersigned, hereby authorize the North Merrick UFSD, to release and provide information about my child specific to medical emergency, Health History and records to any/all appropriate staff members/designee for purposes of being prepared to intervene in the event of an allergic reaction to: _____
Name:_____
Address:_____
Phone: (_____)_____-_____

Additionally, I grant and agree to waive liability for any actions covered under the GOOD SAMARITAN ACT (NYS Public Health Law # 3000A) for any adult who intervenes on behalf of my child by administering antihistamines as part of my child's prescribed treatment plan in an emergency specific to potential Anaphylaxis.
I acknowledge that I understand the purpose of this request and that authorization is hereby granted voluntarily.
Student Name (Last, First, Middle):
_____
Address: _____

Phone: (_____) _____-_____
Date of Birth (mm/dd/yy):_____/_____/_____
_____

NOTE: I understand that this release is valid for a period of one school year. I further understand that I may cancel or revoke this authorization at any time in writing.

Dated this _____ day of _____, _____

By my signature below, I consent to the release of the above listed information / documents.

Printed Name of Parent/: _____
Person in parental supervisor role:

Signature: _____