FOOD ALLERGY ACTION PLAN

Student's Names:______________________________ Date of Birth: ______________Grade: __________

ALLERGY TO: ____

_____ Food Allergy – allergic reaction that occurs when the immune system responds defensively to a specific food protein when ingested.

_____ Food intolerance – an adverse reaction to food that does not involve the immune system and therefore differs from a food allergy.

Any student with a FOOD ALLERGY **must have an *epi-pen* in the nurse's office**

ASTHMATIC YES _____ NO

Please list signs that are usually present during allergy attack:

____

____

Has emergency medical treatment been needed in the past year for allergies?

- No
- Yes (when) ____

Medication	Dose	Route	To Be Given For: Symptoms

Please advise the nurse immediately of changes in dose and/or type of medication.

ACTION:

1. If ingestion is suspected the above criteria will be followed for medication administration.
2. Rescue Squad will be called if epinephrine is administered.
3. Parents will be contacted: Mother ____________________Father ______________________
4. Physician will be contacted: Dr ____________________________ at ______________________.

If you want additional help given, or have other concerns, describe here.

____

According to the TRCSC Food Allergy policy, each student with an allergy must have a yearly Food Allergy Action Plan on file in the nurse's office. **It is the responsibility of parents to provide necessary medicine needed at school.** If you have questions, please call the school nurse.

____________________________MD ___________ ____________________________ ___________

Physician's Signature Date Parent Signature Date

Form Must be completed by physician

Special Dietary Needs Medical Statement

This school/facility participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability or impairment. If you are requesting a meal accommodation or substitution, please complete and sign this form. A physician note or statement may be required. If you have any questions, please contact at .

Parent/Guardian:

Student's Name	Date of Birth	Grade Level/Classroom	Name of School/Site
Name of Parent/Guardian	Phone Number of Parent/Guardian		
Please provide an explanation below of how the student's physical or mental impairment restricts the student's diet.			
Allergies and Intolerances	What food(s)/type(s) of foods should be omitted? Please be as specific as possible.		
	List foods to be substituted.		
Signature of Parent/Guardian	**Date**		

Medical Authority:

Texture Modifications	The child requires foods be: ☐ Pureed ☐ Diced/Finely Ground ☐ Chopped/cut into bite-size pieces ☐ Other (please specify):	Liquids should be: ☐ Pudding Thick ☐ Honey/Nectar Thick ☐ Thinned ☐ Other (please specify):
Adaptive Eating	Provide an explanation of how the student's physical or mental impairment restricts the student's diet	
Additional Information	Describe any additional details for clarification such as required special adaptive equipment:	
Name of Physician/Medical Authority & Title (please PRINT)	Provider Phone Number	
Signature of Physician/Medical Authority	Date	

Signing the following section is optional, but may prevent delays by allowing school personnel to speak with the medical authority.

Health Insurance Portability and Accountability Act Waiver (HIPPA)

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), I hereby authorize ______________________________ **(medical authority)** to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to ______________________________ **(school/program)**, and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the SCHOOL PROGRAM as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on ________(date). This information is to be released for the specific purpose of Special Diet Information. The undersigned certifies that he/she is the parent/guardian/or representative of the person listed on this document and has the legal authority to sign on behalf of that person,

Parent/Guardian Signature:______________________________ **Date**:______________

School/Faculty Use Only:

☐ Form Received on ________________. ☐ Accommodation will begin on ________________.

☐ Accommodations within meal pattern. ☐ Accommodations not within meal pattern.

☐ Form incomplete. Parent contacted on ______.

☐ Form complete. Accommodation will not be made. ☐ Request not reasonable. ☐ 504 coordinator contacted

______________ Date ______________________________ Signature of Food Service Director/Contact

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: ____________

Allergy to: ______________________

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

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

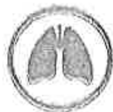
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ____________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____________

Antihistamine Dose: ____________

Other (e.g., inhaler-bronchodilator if wheezing): ____________

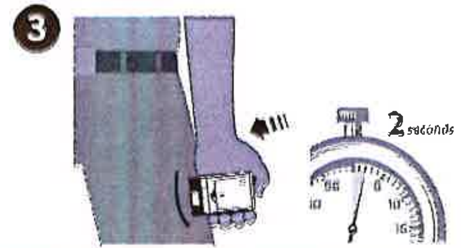
____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

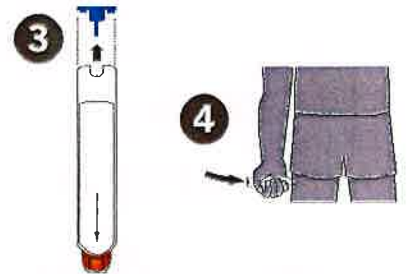
Food Allergy Research & Education

HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO



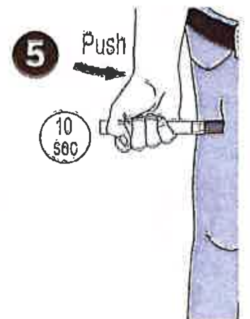
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ____________

PARENT/GUARDIAN: ______________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018