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.

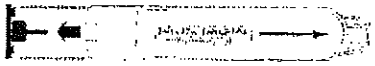
_____ _____ _____ _____

Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

TURN FORM OVER Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)

- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

EpiPen 2-Pak® · EpiPen Jr 2-Pak®

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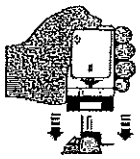
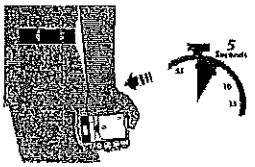
Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.





Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 • Rescue squad: (____) ____-_____ Doctor: _____ Phone: (____) ____-_____
Parent/Guardian: _____ Phone: (____) ____-_____

Other Emergency Contacts
Name/Relationship: _____ Phone: (____) ____-_____
Name/Relationship: _____ Phone: (____) ____-_____

Form provided courtesy of the Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SPONSOR Name	2. Site Name, if different from #1.	3. Site Telephone Number

4. Name of Participant	5. Date of Birth

6. Name of Parent or Guardian	7. Telephone Number

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions.) CACFP, schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, nurse practitioner or parent or guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

12. Foods to be omitted and substitutions: (*please list specific foods to be omitted and required substitution; attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Foods to be Substituted

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date

19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

* Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability. The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.