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 *no symptoms*:		☐ 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_____ Date_____
(Required)

Woodland Park Public School District Allergy Assessment

TO BE COMPLETED BY PARENTS:

Student's Name_____ Date of Birth_____ Grade_____

Physician's Name_____ Physician's Phone Number_____

List all of the allergens that affect your child:

List the allergens that you know could cause a severe allergic anaphylactic reaction in your child:

Describe the signs and symptoms your child exhibits during a mild allergic reaction not requiring the use of epinephrine:

Describe the signs and symptoms your child exhibits during a severe allergic (anaphylactic) reaction requiring the use of epinephrine:

Describe any side effects your child experienced from the use of epinephrine:

Comments and/or Concerns:

_____ _____

Signature of Parent/Guardian Date

Woodland Park Public School District Allergy Treatment Plan (continued)

TO BE COMPLETED BY PHYSICIAN/PROVIDER:

Student's Name_____ **DOB**_____ **Grade**_____

Allergy to: _____

If a pre-filled, single dose auto-injector mechanism of epinephrine is prescribed by you for a severe allergic reaction, it will be administered by the school nurse and/or by a delegate trained by the school nurse when the school nurse is not present.

Medical Authorization:

I authorize the use by the school nurse and/or delegate of a pre-filled, single-dose auto-injector mechanism of epinephrine for this student_____, in the event of a severe allergic reaction (Anaphylaxis).

This authorization will be in effect for the _____school year.

_____ _____

Signature of Physician/Provider Date

Self-Administration Medical Authorization:

I authorize the self-administration of a pre-filled, single-dose auto-injector mechanism of epinephrine by this student_____in the event of a severe allergic reaction. She/he has been instructed in the self-administration of the pre-filled, single-dose auto-injector mechanism and has the capability to self- administer.

This authorization will be in effect for the_____school year.

_____ _____

Signature of Physician/Provider Date

Physician/Provider Stamp

Woodland Park Public School District

Parental Authorization for the Emergency Administration of Epinephrine by School Nurse and Delegates

I authorize the School Nurse and/or a person delegated by the School Nurse when the School Nurse is not available to administer a pre-filled auto-injector mechanism containing epinephrine to my child,_____ (name, grade), If my child is experiencing anaphylaxis and does not have the capability for self-administration of the medication.

I understand, that if the procedures in N.J.S.A 18A:40-12.5 and 12.6 and procedures specified in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate trained by the School Nurse" are followed, Woodland Park Public School District shall have no liability as a result of any injury arising from the administration of a prefilled auto-injector mechanism containing epinephrine to my child. We (the parents/guardians) shall indemnify and hold harmless Woodland Park Public School District, its employees and /or agents and the school nurse, against any claims resulting from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.

I have discussed this protocol with my child's primary health care provider, Dr._____, and will ensure completion of all the required forms.

_____ _____

Signature of Parent/Guardian Date

Self-Administration of Epinephrine

My child_____(name, grade) is capable of self-administration of epinephrine via pre-filled auto-injector.

_____

Signature of Parent/Guardian Date

Declination Statement:

I have read the Policy for the Administration of Epinephrine in the Schools and I **do not want the school nurse and/or delegate to administer epinephrine** to my child_____(name, grade). I understand that in the event of an anaphylaxis emergency the school nurse will contact 911 and the student will be transported to the nearest medical facility for treatment. School personnel will notify the parents/guardians as soon as possible that an anaphylactic reaction has occurred.

_____ _____

Signature of Parent/Guardian Date