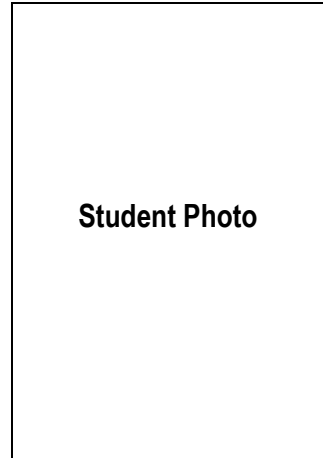


FOOD ALLERGY ACTION PLAN



STUDENT'S NAME: _____ D.O.B. _____

TEACHER: _____

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 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** 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
--	-----------------	-------------------

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

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3mg Twinject™ 0.15mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

Student may carry above medications ___Yes ___No Student may self administer above medications ___Yes ___No

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr. _____ at _____



3. Emergency Contacts:

	NAME/RELATIONSHIP		PHONE NUMBER(S)
a.	_____	1)	_____ 2) _____
b.	_____	1)	_____ 2) _____
c.	_____	1)	_____ 2) _____

Even if parent/guardian cannot be reached, do not hesitate to medicate or take child to medical facility!

Parent/guardian signature _____ Date _____
(Required)

As the authorizing physician, I am willing to accept direct communication from the person dispensing and administering the above medication.

Doctor's signature _____ Date _____
(Required)

To Parent/Guardian/Practitioner: In accordance with state law, school personnel may give prescription medication to students only with complete directions from a practitioner and signed consent by the student's parent/guardian. School personnel may give non-prescription medication to students only with directions and signed consent from parents/guardians. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any other container or package other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

TRAINED STAFF MEMBERS

1.	_____	Room	_____
2.	_____	Room	_____
3.	_____	Room	_____
4.	_____	Room	_____