

Pulaski County Schools Food Allergy Action Plan

**Place
Child's
Picture
Here**

Student's Name: _____ **D.O.B:** _____

ALLERGY TO: _____

Asthmatic Yes* _____ No _____ *Higher risk for severe reaction

TREATMENT PLAN

<u>Symptoms:</u>	<u>Give Checked Medication</u>
▪ If a food allergen has been ingested, but no symptoms:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Throat* Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Lung* Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Heart* Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Other* _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

The severity of symptoms can quickly change. * All above symptoms can potentially progress to a life-threatening emergency.

DOSAGE

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

Antihistamine: give _____
Medication/dose/route

Even if Parent/Guardian cannot be reached, DO NOT hesitate to give medication ordered or call 911.

EMERGENCY PLAN OF ACTION

1. **Call 911. 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 Contact:** _____ **Phone Number** _____

____ This student has been instructed in the proper way to use his/her Epi Pen. It is my professional opinion that this student is responsible and should be allowed to carry and self-administer his/her EpiPen.

____ This student has an order for Benadryl (Diphenhydramine HCL) and has been instructed on when to use for symptoms of allergic reaction. **Student may carry only one dose for self administration.**

____ It is my professional opinion that **this student should not carry his/her Epi Pen or antihistamine at school.** The Epi Pen/antihistamine will be kept in the health clinic and administered by school nurse and/or designated trained staff.

This plan of care is in accordance with the student's medical management and is to be followed at school.

Physician Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

Revised: May 2, 2011

Student Name: _____ DOB: _____

The following is to be completed by parent/guardian

What is your child allergic too: _____

How many times has your child been seen in the emergency room for this condition in the last year? _____

Please list symptoms your child has had during previous allergic reaction: _____

Other comments/instructions: _____

Outline a plan for classroom parties and/or food in classroom: _____

Outline a plan for field trips: _____

Outline a plan for when your child is riding the bus to and from school: _____

Will this student be carrying an Epi Pen* on the bus? _____

Parent /Guardian Consent: I have received and approve this health care and emergency action plan for my child. I authorize unlicensed trained personnel of Pulaski County Schools to administer and/or assist my child with an **Epi Pen** (epinephrine) and/or other prescribed medication as outlined in this plan in the absence of the school nurse. I understand that I am responsible for supplying any medication, supplies and/or equipment, and dietary supplements needed by my child to manage his/her allergy/reaction. This health care plan can be updated at any time my child's circumstances require modifications in treatment, but will be reviewed annually. I agree to notify the school if a change occurs in my child's health plan. I also consent to the release of the information contained in this care plan to Pulaski County School personnel who care for my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

TRAINED STAFF MEMBERS

1.	Location:
2.	Location:
3.	Location:

Directions for Use of Epi Pen:

- 1. Remove gray cap**
- 2. Place black tip on outer thigh**
- 3. Jab firmly into outer thigh until auto-injector activates**
- 4. Hold in place for several seconds**
- 5. Remove injector and massage injection area for 10 seconds**
- 6. Check black tip: if needle is exposed, you received the medication, if not repeat # 3-5**
- 7. GO IMMEDIATELY TO THE NEAREST HOSPITAL EMERGENCY ROOM. You may need further medical treatment. Tell the physician that you have received an injection of epinephrine. Give your used Epi Pen to the physician for inspection and proper disposal.**

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