Educational Service Center
of Medina County
"Stepping Up to Excellence"

Student Photo ID

Food Allergy Action Plan

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name:	**Phone (Family):**
Address:	
Emergency Number:	
Physician:	**RN:**
Emergency Medication Location:	

Allergy to: _____

Weight: _____ **lbs.** **Asthma:** _____ **Yes (higher risk for a severe reaction)** _____ **No**

Extremely reactive to the following foods:

_____ **Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.**

_____ **Give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.**

1. 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

Treatment:
1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911.
3. Begin monitoring.
4. Give additional medications (if ordered):
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

2. MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

Treatment:
1. GIVE ANTIHISTAMINE.
2. If symptoms progress (see above), USE EPINEPHRINE.
3. Begin monitoring.

MEDICATIONS/DOSES

Epinephrine (brand and dose):

Antihistamine (brand and dose):

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

This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian Date

Parent/Legal Guardian Date

RN Date

MEDICAL REVIEW

I have reviewed the attached Action Plan for _____, AND:

I approve the Action Plan as written.

I approve the Action Plan with the attached amendments.

I do not approve of the Action Plan as written, and substitute orders are attached.

Physician Date

OTHER RECOMMENDATIONS

Copies to:

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other