MIDDLETON PEDIATRICS

# Food Allergy Action Plan

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

**Allergy To:**_____

**Weight:**_____Lbs. **Asthmatic:** Yes (higher risk for severe reaction) ☐ No ☐

**Place Student's Picture Here**

**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 if the allergen was *definitely* eaten, even if no symptoms are noted.

**Step 1: Treatment Plan**
(Give Checked Medication. All medication must be authorized by physician.)

| **Symptoms:** | **Epinephrine** | **Antihistamine** |
|---|---|---|
| If a food allergen has been ingested, but no symptoms | | |
| **If Severe:** shortness of breath, faint, weakness, swelling of mouth/lips/throat/tongue, repeat vomiting | | |
| **If Mild:** Hives, itchy rash, tingling of lips, | | |
| **Other**: | | |
| If reaction is progressing (several of the above areas affected) | | |
| **Allergic reactions are life-threatening. The severity of symptoms can quickly change.** | | |

**Medication/Doses**
Epinephrine: inject intramuscularly (check one) ____EpiPen® ____EpiPen® Jr.

Antihistamine: give_____
Medication/dose/route

Other: give_____
Medication/dose/route

**Monitoring**
**Stay with student; alert healthcare professionals and parent/legal guardian.** 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 students even if parents cannot be reached. See attached for auto-injection technique.

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

___It is my professional opinion that this student should not carry his/her EpiPen® at school. The EpiPen® will be kept in the health clinic and be 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.*

**Parent/Legal Guardian Signature**_____**Date**_____

**Physician Signature**_____**Date**_____
(Required)

Student Name:_____D.O.B:_____

## The following is to be completed by parent/guardian

**Step 2: Emergency Action Plan**

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 Contacts:**

| Name/Relationship | Phone Number(s): |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911**

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 reactions:_____

_____

Other comments/instructions:_____

_____

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

_____

Outline a plan for field trips:_____

_____

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

_____

Will this child be carrying an EpiPen® on the bus?_____

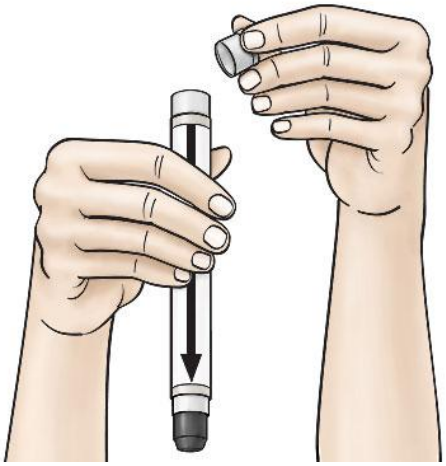
***Parent/Legal Guardian Consent:*** *I have received and approve this health care and emergency action plan for my child. I authorize unlicensed trained personnel of my child's school to administer and/or assist my child with an EpiPen® (epinephrine) and/or other prescribed medication as outlined in this plan in the absence of a school nurse. I understand that I am responsible for supplying any medication, supplies, and dietary supplements needed by my child to manager his/her allergy. 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 my school personnel who cares for my child and who may need to know this information to maintain my child's health and safety.*

**Parent/Legal Guardian Signature_____Date_____**

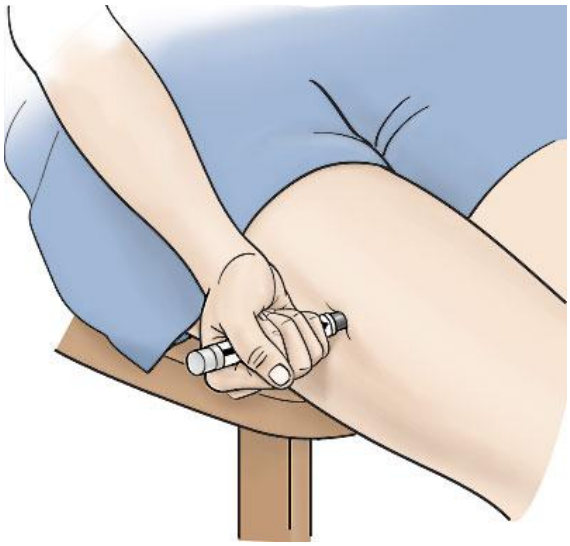
**School Nurse Signature_____Date_____**

Student Name:_____D.O.B:_____

## EPIPEN® and EPIPEN® Jr. DIRECTIONS



**Remove EpiPen® Auto-Injector from plastic carrying case. Pull off blue safety release cap.**



**Hold orange tip near outer thigh (always apply to thigh). Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

**Trained Staff Members**

**1._____ Room_____**

**2._____ Room_____**

**3._____ Room_____**