



School Year _____

FOOD ALLERGY HEALTH ACTION PLAN

Student Name _____

Date of Birth _____ Grade _____ Grad Year _____

School _____ Teacher/HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can reach you during the school day in case of emergency.

Phone 1. _____	H/C/W _____	Name/Relationship _____
Phone 2. _____	H/C/W _____	Name/Relationship _____
Phone 3. _____	H/C/W _____	Name/Relationship _____
Phone 4. _____	H/C/W _____	Name/Relationship _____
Email for Health Plan updates: _____		

FOOD ALLERGY: _____

Physician student sees for Allergy _____ Phone _____

My child has a reaction when he/she:

- Eats a food or another food containing the food allergen
- Touches a surface contaminated with oils from the food allergen
- Breaths odors from the food allergen while food is being cooked or processed

Check the symptoms your child has during a severe allergic reaction:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Hives/Rash | <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling
Arms/Legs | <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Cramping / Abdominal
Pain | <input type="checkbox"/> Swollen lips /
tongue |
| <input type="checkbox"/> Hacking Cough | Other: _____ | | |

Onset of symptoms after ingestion or contact:

- Immediately
- Within 15 minutes
- Within 1 hour
- Within 2 hours
- Varies/Unknown

Does your child require an antihistamine at school? Yes____ No____

Medications/Dose _____

Does your child require Epinephrine at School? Yes____ No____

Has your child ever needed epinephrine before? Yes____ No____

Explain: _____



NOTE: Parents are responsible for providing medications given at school. A [Medication Authorization Form](#) needs to be filled out and signed by a parent/guardian and health care provider annually.

PLEASE COMPLETE AND SIGN NEXT PAGE →

Student Name _____

EMERGENCY ACTION PLAN -STEPS TO TAKE DURING AN ALLERGIC REACTION

If you see this: Mild Reaction _____, Do This:

- Have student come to the office/health room with an escort
- Call parent/guardian to inform them of situation and get permission to give antihistamine (such as Benadryl) Give _____ mg _____ antihistamine orally
- Locate the student's epinephrine pen or retrieve a STOCK EpiPen if theirs cannot be located
- Continue to monitor for 20-30 minutes and observe for signs and symptoms of **anaphylaxis**

IF YOU SEE THIS: ANAPHYLAXIS, A SEVERE ALLERGIC REACTION

Mouth: Itching, tingling, or swelling of the lips, tongue, or mouth.

Throat: Itching or tightening in the throat, hoarseness, hacking cough.

Skin: Hives, itchy rash, swelling of the face or extremities.

Gut: Nausea, abdominal cramps, vomiting, diarrhea.

Lungs: Shortness of breath, repetitive coughing, wheezing.

Heart: Weak or irregular pulse, low blood pressure, faintness, pale, blue



DO THIS: FOR SEVERE ANAPHYLACTIC REACTION

- **Call the school office to have the EpiPen brought to student immediately**
- **Have the office call a Medical Emergency Response and Call 911**
- **If the student does not have their EpiPen at school, use a STOCK EpiPen**
- **Administer the EpiPen immediately. May repeat with a second EpiPen after 5-20 minutes.**
 - √ Dispose of needle and injector in a red sharps container
 - √ Give EpiPen package and a copy of this health plan to rescue personnel
- Notify parent/guardian (EpiPen administration and calling 911 take priority over parent notification)
- Notify building principal and school nurse, if not already aware
- Complete an [Accident/Incident Report](#) and [Medical Emergency Response Team Report](#)

Memo of Understanding:

- It is the mutual responsibility of parent & teacher to review party/field trip menus and make arrangements.
- It is the responsibility of the parent to review breakfast and lunch menus with their child.
- It is understood that students are not allowed to share food or eating utensils at school.
- It is understood that a parent will complete and sign a Food Allergy Health Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the school nurse of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Anna Lisiecki, BSN, RN

