



Food Allergy Action Plan / Nutritional Medical Statement
(To Be Renewed Every School Year)

Child's Name: _____ School: _____
Address: _____ DOB: _____
Telephone: _____ Teacher: _____
Grade: _____ Student ID#: _____

Allergic To: _____

If Asthmatic: *Yes ___ No ___ * High Risk for Severe Reaction

Diagnosis: (Include description of student's medical or other special dietary needs that restrict the child's diet)

List food(s) to be omitted from diet:

List food(s) that may be substituted (Diet Plan):

Length of time diet will be required:

Additional Information:

Signs of An Allergic Reaction

<u>System</u>	<u>Symptoms</u>
Mouth	Itching & swelling of lips, tongue or mouth
Throat	Itching and/or a sense of tightness in throat, hoarseness, hacking cough
Skin	Hives, itchy rash, and/or swelling of face or extremities
Abdomen	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	"Thready" pulse, "passing out"

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

Action for Minor Reaction

If only symptom(s) are: _____, give _____
(medication/dose/route)

Then call:

1. Mother _____ Father _____ or emergency contacts.
2. Dr. _____ at _____

October 2, 2009

If condition does not improve within 10 minutes, follow steps for Major Reaction below.



Action for Major Reaction

If ingestion is suspected and/or symptom(s) are: _____,
 give _____ IMMEDIATELY!
 (medication/dose/route)

Then call:

1. Rescue Squad (ask for advanced life support)
2. Mother _____, Father _____, or emergency contacts.
3. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD (911)

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child.

Parent / Guardian Signature _____
Date

Physician Signature/Printed and/or Stamped _____
Date

Phone and Fax Numbers

Emergency Contacts	Trained Staff Members
1. _____ / _____ (Relation) (Date)	1. _____ Rm. _____
2. _____ / _____ (Relation) (Date)	2. _____ Rm. _____
3. _____ / _____ (Relation) (Date)	3. _____ Rm. _____

EPIPEN AND EPIPEN JR. DIRECTIONS

1. Pull off gray activation cap.
2. Hold back tip near outer thigh (always apply to thigh).
3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.

 School Nurse Signature / Date

 Cafeteria Manager Signature / Date

October 2, 2009