Food Allergy Management Plan

Name: _____**D.O.B.:** ____/____/____

Allergy to: _____

Weight: ____lbs. **Asthma:** ☐ Yes (higher risk for a 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 immediately if the allergen was *definitely* eaten, even if no symptoms are noted.
☐ Student may carry/use his or her EPI-PEN or other automated epinephrine injector

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

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Follow any additional instructions if prescribed by healthcare provider.
5. If symptoms get worse or do not go away within 10-15 minutes, give a second dose of epinephrine.

Medications/Doses

Epinephrine (brand and dose): _____

Other instructions: _____

Common side effects of Epinephrine include: paleness, shaking, anxiety, fast heart rate, headache, and nausea.

I authorize the exchange of medical information about my child's allergies between the physician's office and school nurse. I request treatment be administered in accordance with my child's licensed healthcare provider's orders. I will notify the school if my child's health status changes or we change healthcare providers. I agree to provide all necessary equipment and supplies properly labeled and further agree to hold the Elko County School District, the Board of Trustees, and all agents of the District harmless from any liability for their participating in assisting and supervising the above named student with the Allergy Management Plan.

Parent/Guardian signature: _____ Date: _____

My child's Physician/Healthcare Provider Name: _____

Phone: (___) ___-_____ Fax: (___) ___-_____

_____ _____

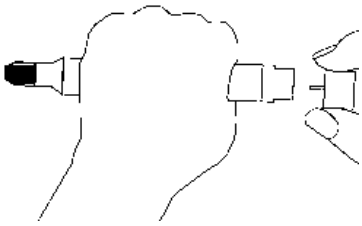
Physician/Healthcare Provider Signature **Date**

Form provided, in part, courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 5/2014 / updated 8/2015

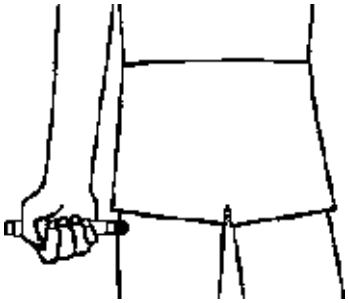
EPIPEN®
(Epinephrine) Auto-Injectors 0.3/0.15mg

- First remove the EPIPEN Auto-Injector from the plastic carring case

- Pull off the blue safety release cap



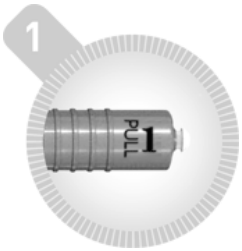
- Hold tip near outer thigh



- Swing and firmly push tip against outer thigh. Hold on thigh for approximately 10 seconds.

How to use Adrenaclick®

New single-dose Adrenaclick®: Easy as...



Remove the GRAY cap labeled "1". Never put thumb, finger, or hand over the RED tip

Remove the GRAY cap labeled "2"

Place RED tip on the middle of the outer side of the thigh. Press down hard until the needle penetrates the skin and slowly count to 10

Check the RED tip. If the needle is exposed, you received the dose. If needle is not visible, repeat step 3.

*Call 911 after administering Adrenaclick® to get medical attention.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

*Another brand of epinephrine auto-injector may be prescribed. Please see manufacturer instructions.

Contacts: Parent/Guardian: _____ Phone: (_____) _____

Other Emergency Contacts:

Name/Relationship: _____ Phone: (_____) _____

Name/Relationship: _____ Phone: (_____) _____

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