Food Allergy Action Plan
New Kent County Public Schools

Name: ___________________________ DOB: ___________________________

Allergy to: _______________________________________________________

Weight: __________ lbs.   Asthma: □ No  □ Yes (higher risk for a severe reaction)

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.

Any SEVERE SYMPTOMS after suspected or known ingestion:
One or more of the following:
LUNG: Short of breathe, 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, crampy pain

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

1. INJECT EPINEPHRINE IMMEDIATELY
   2. Call 911
   3. Begin monitoring (see box below)
   4. Give additional medications.*
      - Antihistamine
      - Inhaler (bronchodilator) if asthma

   Antihistamines & inhalers/ bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

1. GIVE ANTIHISTAMINE
   2. Stay with student; alert healthcare professionals and parent
   3. If symptoms progress (see above), USE EPINEPHRINE
   4. Begin monitoring (see box below)

DOSAGE
Epinephrine: inject intramuscularly (check one)
□ EpiPen®
□ EpiPen® Jr.
□ Twinject® 03. Mg
□ Twinject® 0.15 mg

Antihistamine: give ____________________________________________
Medication, dose, route

Other: give ___________________________________________________
Medication, dose, route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

PLEASE NOTE: A physician’s order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.
INSTRUCTIONS FROM PHYSICIAN:

☐ I have instructed this student in the proper use of his/her emergency medication for anaphylaxis. This student should be able to carry and use this medication at school independently.

☐ This student needs assistance using his/her emergency medication for anaphylaxis in school.

Physician Signature                  Phone Number                  Date

PARENT PERMISSION:
By signing this form, I give permission for the school to use the above plan to manage my child’s allergy. The school may contact my child’s physician regarding their allergy. I understand that I may request to meet with the counselor to discuss educational accommodations that may be needed in the school setting.

Parent Signature                  Date                  RN Signature                  Date

CONTACTS:
Call 911
Doctor: ____________________________ Telephone: ____________________________
Parent/ Guardian: ____________________ Telephone: ____________________________
Parent/ Guardian: ____________________ Telephone: ____________________________

Other Emergency Contacts:
Name/ Relationship: ____________________ Telephone: ____________________________
Name/ Relationship: ____________________ Telephone: ____________________________

MONITORING: Stay with student; alert healthcare professionals and parent. 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 reoccur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Trained Staff Members:
1. ___________________________________________  2. ________________________________
3. ___________________________________________  4. ________________________________