Food Allergy Action Plan

Emergency Care Plan

(This form must be updated yearly)

D.O.B.: / /

Student
Picture

Place

Name:	D.O.B.://	Picture			
Allergy to:		Here			
Weight:lb.	Asthma: Yes (Higher Risk for Severe Reaction) No				
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 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.

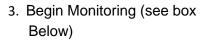
Or combination of symptoms from different body areas:

Skin: Hives, itchy rashs, swelling (I.g eyes & lips)

Gut: Vomiting, diarrhea, crampy pain.

1. INJECT EPINEPHRINE IMMEDIATELY!





- 4. Give additional medications*
 - -Antihistamines
 - -Inhaler (bronchodilator) If

Asthma.

Mild Symptoms Only:

Mouth: Itchy Mouth

Skin: A few hives around mouth/face, mild itch

Gut: Mild nausea/discomfort

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1. GIVE ANTIHISTAMINE

- Stay with student; alert health care professionals & parent
- **3.** If symptoms progress see above.
- **4.** Begin Monitoring (see below)

Medications / Doses

Epinephrine (brand & dose):_______Antihistamine (name & dose)

Other (e.g., inhaler-bronchodilator if asthmatic):

Monitoring:

Stay with student; alert health care professionals and parent. Tell rescue squad that epinephrine was given and at what time. A second dose 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 student even if parents cannot be reached.

Physician Signature:	Date	Parent/Guardian Signature	Date

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Glendale Elementary School District Medical / Special Diet Request Form

Child's Name:	Date of Birth:	School:
Parent's Name:	Phone #:	
Diagnosis related to diet Modifications	S:	
Major life activity affected:		
IMPORTANT NOTE: WE CANNOT ACCEPHYSICIAN'S NOTE. If this is a dietary prescription for a child with the control of the control	with disabilities, it must be (DO). For special dietary which also includes a na	e signed by a Doctor of Medicine needs for a child without disabilities turopathic physician, Physician's
Parent/Guardian:	Date	: :
Foods to be omitted from child's diet:		
Foods to be substituted:		
Special Considerations:		
<u> </u>		
Please Check: Life Threatening (critical, needs close super Managed by child with moderate supervisior Self- controlled by child	•	
Physician's Name (Print) OR	Signature	
Medical Authority Name (Print)	Signature	
Phone:()Date:		
I have read and agree with the above information	ation provided by my health ca	are provider;
Parent/Guardian Signature:	Date	