*Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.*

| **STUDENT NAME:** | **DATE OF BIRTH:** |
|---|---|
| **SCHOOL:** | **GRADE:** |

# PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

*The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.*

## Student has a life-threatening or severe allergy to:

| | INGESTION | INHALATION | INJECTION (STING/BITE) | SKIN CONTACT |
|---|---|---|---|---|
| _____ | ☐ | ☐ | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ |

## ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- ☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
- ☐ General: panic, sudden fatigue, chills, fear of impending doom
- ☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth
- ☐ Respiratory: shortness of breath, repetitive coughing, wheezing
- ☐ Skin: hives, itchy rash, swelling about face or extremities
- ☐ Throat: feeling tightness in the throat, hoarseness, hacking cough
- ☐ Other: _____

Treatment:

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

**Student may carry & self-administer epinephrine**
**□ YES □ NO**

## Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

| **Foods to omit:** | **Substitutions:** | **Foods to omit:** | **Substitutions:** |
|---|---|---|---|
| ☐ Eggs | | ☐ Milk | |
| ☐ Whole | _____ | ☐ Milk | _____ |
| ☐ Ingredient in Recipe | _____ | ☐ Cheese | _____ |
| ☐ Other | _____ | ☐ Whey | _____ |
| ☐ Wheat | _____ | ☐ Ingredient in Recipe | _____ |
| ☐ Gluten | _____ | ☐ Other | _____ |
| ☐ Trace Amount | _____ | ☐ Nuts | _____ |
| ☐ Ingredient in Recipe | _____ | ☐ Tree Nut | _____ |
| ☐ Soy | _____ | ☐ Peanut | _____ |
| ☐ Soy Lecithin | _____ | ☐ Other | _____ |
| ☐ Oil | _____ | ☐ Fish | _____ |
| ☐ Isolated Soy Protein | _____ | ☐ Shellfish | _____ |
| ☐ Ingredient in Recipe | _____ | ☐ Other Not Included on List | _____ |
| ☐ Other | _____ | | |

**Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.**

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____

Asthma: (circle) YES NO _____

**Response for reaction to all other allergens:** *Give prompt treatment if the student has any of the following symptoms:*

_____

_____

Treatment:

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO AP PA Date: _____

Healthcare Provider Name (signature): _____ Phone: _____

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

**Parent Signature:** _____ **Date:** _____ **Phone #:** _____