

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
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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):

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

I treatment:

- Administer epinephrine (dosage/route/interval) \_\_\_\_\_
- Call 911
- Continue with monitoring by the nurse until EMS arrives
- Other: \_\_\_\_\_

## 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:

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### Substitutions:

- |   |       |   |       |
|---|-------|---|-------|
| <input type="checkbox"/> Eggs                 | _____ | <input type="checkbox"/> Milk                       | _____ |
| <input type="checkbox"/> Whole                | _____ | <input type="checkbox"/> Milk                       | _____ |
| <input type="checkbox"/> Ingredient in Recipe | _____ | <input type="checkbox"/> Cheese                     | _____ |
| <input type="checkbox"/> Other                | _____ | <input type="checkbox"/> Whey                       | _____ |
| <input type="checkbox"/> Wheat                | _____ | <input type="checkbox"/> Ingredient in Recipe       | _____ |
| <input type="checkbox"/> Gluten               | _____ | <input type="checkbox"/> Other                      | _____ |
| <input type="checkbox"/> Trace Amount         | _____ | <input type="checkbox"/> Nuts                       | _____ |
| <input type="checkbox"/> Ingredient in Recipe | _____ | <input type="checkbox"/> Tree Nut                   | _____ |
| <input type="checkbox"/> Soy                  | _____ | <input type="checkbox"/> Peanut                     | _____ |
| <input type="checkbox"/> Soy Lecithin         | _____ | <input type="checkbox"/> Other                      | _____ |
| <input type="checkbox"/> Oil                  | _____ | <input type="checkbox"/> Fish                       | _____ |
| <input type="checkbox"/> Isolated Soy Protein | _____ | <input type="checkbox"/> Shellfish                  | _____ |
| <input type="checkbox"/> Ingredient in Recipe | _____ | <input type="checkbox"/> Other Not Included on List | _____ |
| <input type="checkbox"/> 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 allergies: Give prompt treatment if the student has any of the following symptoms:

\_\_\_\_\_

Treatment:

- Administer: \_\_\_\_\_
- Contact: \_\_\_\_\_
- Other: \_\_\_\_\_

Healthcare Provider Name (printed): \_\_\_\_\_ MD DO APN 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 #: \_\_\_\_\_