Fulton County Schools
Where Students Come First

Student Health Services

Food Allergy Care Plan

Student's Name _____ DOB: _____ Teacher_____

School_____ Grade_____ (*Please attach picture to Care Plan)

ALLERGY TO: _____

□ ***Box checked indicates a severe food allergy which may lead to anaphylaxis.***

Asthmatic Yes*□ No□ *Higher risk of severe reaction *Inhaler at school? Yes___ No ___ Carries___

***Fulton County School Nutrition Program cannot guarantee that food products served in school cafeterias were not processed in plants that also process nut products.**

STEP 1: TREATMENT

Symptoms:	Give Checked Medication**: **(To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but *no symptoms*:	□Epinephrine	□ Antihistamine
Mouth* Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine	□ Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	□Epinephrine	□ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine	□ Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	□Epinephrine	□ Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	□Epinephrine	□ Antihistamine
Heart*: Thready pulse, low blood pressure, fainting, pale, blueness	□Epinephrine	□ Antihistamine
Other* _____	□Epinephrine	□ Antihistamine
If reaction is progressing (several of the above areas affected),	□Epinephrine	□ Antihistamine

***Food Allergy is potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for administration instructions)_____

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.

STEP 2: EMERGENCY CALLS

1. Call 911 or Rescue Squad: _____.
*State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Physician's Full Name: _____ Office Phone:_____
3. Emergency contacts: Name/Relationship and Phone Number(s)

a. _____ 1._____ 2._____
b. _____ 1._____ 2._____
c. _____ 1._____ 2._____

Parent/Guardian Signature_____Date_____

Physician Name (***print legibly***) _____ Signature_____ Date_____
(Physician's signature required)

Date Received: _____ Cluster Nurse/Special Education Nurse Signature:_____