



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

<u>Symptoms:</u>	<u>Give Checked Medication**:</u>
	** (To be determined by physician authorizing treatment)
If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Mouth* Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Heart*: Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Other* _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected),	<input type="checkbox"/> Epinephrine <input type="checkbox"/> 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: _____
SHS/School Nutrition Jul 2011