



Student Health Services

Food Allergy Care Plan

Where Students Come First

Student's Name _____ D.O.B. _____ 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. Dr's full name: _____ Office Phone: _____

3. Emergency contacts: Name/Relationship Phone Number(s)

a. _____ 1. _____ 2. _____

b. _____ 1. _____ 2. _____

c. _____ 1. _____ 2) _____

Parent/Guardian Signature _____ Date _____

Physician's Name (*print legibly*) _____ Signature _____ Date _____

(Physician's signature required)

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