



# 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: \_\_\_\_\_