

Food Allergy Information Sheet

History

Child's Name: _____ Grade: _____

Food Allergy (list): _____

Please describe the reaction: (indicate – inhalation/contact/ingestion etc) _____

Most recent allergic reaction (describe): _____

Has allergy testing been done and foods confirmed? _____

What are the first signs of an allergic reaction for you child (describe): _____

Treatment

If your child has been prescribed an Epi-pen or Benadryl, please get a medication order form from the Physician for school. The order and medication needs to be brought in the first week of school and given to the nurse. A new order is required **each** school year. Please consult with the nurse in order to prepare for the school year and develop a plan with your child's teacher.

It is **highly recommended** that you **provide snacks** for you child to have in the classroom for special events (i.e. birthdays, class parties etc.) so your child will not feel left out or deprived. This also maintains a safe alternative for your child.

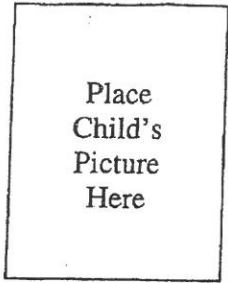
Ways to reduce an allergic event from occurring are:

- Review with your child what foods to avoid and to eat only what is in his/her lunch.
- Not to share foods or accept any food/candy from classmates.
- Provide a selection of **safe** snack alternatives to your child's teacher at the **beginning** of the school year (for special events- birthdays, classroom parties etc.).
- Talk with the school nurse to develop an action plan.
- Parents will inform the nurse of any changes in allergies or treatments. And inform the teacher of any special accommodations for your child at school.
- Be willing to accompany your child on field trips, depending on severity of allergy.

Parent Signature: _____ Date: _____

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
 - Mouth Itching, tingling, or swelling of lips, tongue, mouth
 - Skin Hives, itchy rash, swelling of the face or extremities
 - Gut Nausea, abdominal cramps, vomiting, diarrhea
 - Throat† Tightening of throat, hoarseness, hacking cough
 - Lung† Shortness of breath, repetitive coughing, wheezing
 - Heart† Thready pulse, low blood pressure, fainting, pale, blueness
 - Other† _____
 - If reaction is progressing (several of the above areas affected), give
- The severity of symptoms can quickly change. †Potentially life-threatening.

Give Checked Medication**:

(To be determined by physician authorizing treatment)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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DOSAGE

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

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

◆ 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. _____ at _____

3. Emergency contacts:
Name/Relationship

Phone Number(s)

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

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____

Date _____

Doctor's Signature _____

Date _____

(Required)