Food Allergy Action Plan
Emergency Care Plan

Name: ____________________________ D.O.B.: _____ / _____

Allergy to: ____________________________________________

Weight: ______ lbs. Asthma: □ Yes (higher risk for a severe reaction) □ No

Extremely reactive to the following foods: ________________________________

THEREFORE:
□ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
□ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

Medications/Doses
Epinephrine (brand and dose):
Antihistamine (brand and dose):
Other (e.g., inhaler-bronchodilator if asthmatic):

Monitoring
Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature ____________________________ Date ________

Physician/Healthcare Provider Signature ____________________________ Date ________

TURN FORM OVER Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011
EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap
- Hold orange tip near outer thigh (always apply to thigh)
- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

- Remove GREY caps labeled "1" and "2."
- Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student’s physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: ___-___) Doctor: ____________ Phone: (___) ___-_____
Parent/Guardian: ____________________________ Phone: (___) ___-_____

Other Emergency Contacts

Name/Relationship: ____________________________ Phone: (___) ___-_____
Name/Relationship: ____________________________ Phone: (___) ___-_____

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011
# Student Asthma/Allergy Action Plan

*(This Page To Be Completed By Parent/Guardian)*

**Student Name:**

**Age:**

**Grade:**

**School:**

**Homeroom Teacher:**

**Parent/Guardian:**

**Phone(H) (W) Phone(H) (W)**

**Parent/Guardian:**

**Phone(H) (W)**

**Alternate Emergency Contact:**

**Phone(H) (W)**

## Known Asthma Triggers:
Please check the boxes to identify what can cause an asthma episode for your student:

- Exercise
- Respiratory/viral infections
- Pollens
- Animals/dander
- Temperature/weather—humidity, cold air, etc.
- Other—please list:

- Odors/fumes/smoke
- Dust/dust mites
- Mold/mildew
- Grasses/trees
- Pesticides
- Food—please list below

## Known Allergy/Intolerance:
Please check those which apply and describe what happens when your child eats or comes into contact with the allergen:

- Peanuts
- Tree Nuts
- Fish/shellfish
- Eggs
- Soy
- Wheat
- Milk
- Medication
- Latex
- Insect stings
- Other

**Notice:** If your child has been prescribed epinephrine (e.g. EpiPen) for an allergy, it is also necessary to provide epinephrine at school. If your student requires a special diet to limit or eliminate foods, your school may ask your physician to complete the form “Medical Statement for Students Requiring Special Meals”.

## Daily Medications:
Please list daily medications used at home and/or to be administered at school.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Amount/Dose</th>
<th>When administered</th>
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</table>

I understand that all medications to be administered at school must be provided by the parent/guardian.

**Parent signature:**

Date: 

Reviewed by school nurse/nurse designee:

Date: 

Version: 06/11
Student Asthma/Allergy Action Plan

(Student Name: ____________________________ Date Of Birth: __________/____/____)

☐ Exercise Pre-Treatment: Administer inhaler (2 inhalations) 15-30 minutes prior to exercise. (e.g., PE, recess, etc).
☐ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
☐ Levalbuterol (Xopenex HFA)
☐ Pirbuterol inhaler (Maxair)

☐ Use inhaler with spacer/valved holding chamber
☐ May carry & self-administer inhaler (MDI)
☐ Other: ____________________________

Asthma Treatment

Give quick relief medication when student experiences asthma symptoms, such as coughing, wheezing or tight chest.

☐ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Pirbuterol (Maxair) 2 inhalations
☐ Use inhaler with spacer/valved holding chamber
☐ May carry & self-administer inhaler (MDI)
☐ Albuterol inhaled by nebulizer (Proventil, Ventolin, AccuNeb)
  ☐ .63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 mL
☐ Levalbuterol inhaled by nebulizer (Xopenex)
  ☐ 0.31 mg/3 mL ☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL
☐ Other: ____________________________

Closely Observe the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are improved, student may return to classroom after notifying parent/guardian
- No improvement in symptoms, repeat the treatment and notify parent/guardian immediately
- If student continues to worsen, CALL 911 and initiate the Nebraska Schools’ Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol

☐ This student has a medical history of asthma and/or anaphylaxis and I have reviewed the use of the above-listed medication(s). If medications are self-administered, the school staff must be notified.

Additional information: (i.e. asthma triggers, allergens)

Anaphylaxis Treatment

Give epinephrine when student experiences allergy symptoms, such as hives, difficulty breathing (chest or neck “sucking in”), lips or fingernails turning blue, or trouble talking (shortness of breath).

☐ EpiPen® 0.3 mg
☐ EpiPen® Jr. 0.15 mg
☐ Twinject™ 0.3 mg
☐ Twinject™ 0.15 mg
☐ Adrenaclick® 0.3 mg
☐ Adrenaclick® 0.15 mg
☐ Other: ____________________________

May carry & self-administer epinephrine

CALL 911 After Giving Epinephrine & Closely Observe the Student

- Notify parent/guardian immediately
- Even if student improves, the student should be observed for recurrent symptoms of anaphylaxis in an emergency medical facility
- If student does not improve or continues to worsen, initiate the Nebraska Schools’ Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol

Physician name: ____________________________ Phone: ____________________________
Physician signature: ____________________________ Date: ____________________________
Parent signature: ____________________________ Date: ____________________________
Reviewed by school nurse/nurse designee: ____________________________ Date: ____________________________

Version: 06/11
Non-Food Allergy/Non-Asthma
STUDENT FORM

Name of Child(ren)       Birthdate

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

To the best of my knowledge, my son(s) and/or daughter(s) have no known Food
Allergies or Asthma. In the event of a food allergy or asthma attack, I understand
that the school staff will follow protocol as described in the school handbooks.

___________________________________________________________________
Parent’s Signature        Date

___________________________________________________________________

Please complete and return by October 31st. Forms can be turned in to the office,
mailed to the school (Attention: Sue Doerr), emailed to vcritchl@esu1.org, or
faxed to the school at 402-586-2406 (Attention: Sue Doerr).

Please notify the school of any changes to your child’s condition.