

Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

<b>STUDENT NAME:</b> _____	<b>DATE OF BIRTH:</b> _____
<b>SCHOOL:</b> _____	<b>GRADE:</b> _____

## PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

### Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- |  |   |
|--|---|
| <input type="checkbox"/> Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea          | <input type="checkbox"/> Respiratory: shortness of breath, repetitive coughing, wheezing    |
| <input type="checkbox"/> General: panic, sudden fatigue, chills, fear of impending doom      | <input type="checkbox"/> Skin: hives, itchy rash, swelling about face or extremities        |
| <input type="checkbox"/> Mouth: itching, tingling, or swelling of the lips, tongue, or mouth | <input type="checkbox"/> Throat: feeling tightness in the throat, hoarseness, hacking cough |
|  | <input type="checkbox"/> Other: _____   |

Treatment:

1. Administer epinephrine (dosage/route/interval) \_\_\_\_\_
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: \_\_\_\_\_

### Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

<b>Foods to omit:</b>	<b>Substitutions:</b>	<b>Foods to omit:</b>	<b>Substitutions:</b>
<input type="checkbox"/> Eggs <input type="checkbox"/> Whole _____ <input type="checkbox"/> Ingredient in Recipe _____ <input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Milk <input type="checkbox"/> Milk _____ <input type="checkbox"/> Cheese _____ <input type="checkbox"/> Whey _____ <input type="checkbox"/> Ingredient in Recipe _____ <input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Wheat <input type="checkbox"/> Gluten _____ <input type="checkbox"/> Trace Amount _____ <input type="checkbox"/> Ingredient in Recipe _____	_____	<input type="checkbox"/> Nuts <input type="checkbox"/> Tree Nut _____ <input type="checkbox"/> Peanut _____ <input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Soy <input type="checkbox"/> Soy Lecithin _____ <input type="checkbox"/> Oil _____ <input type="checkbox"/> Isolated Soy Protein _____ <input type="checkbox"/> Ingredient in Recipe _____ <input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Fish _____ <input type="checkbox"/> Shellfish _____ <input type="checkbox"/> Other Not Included on List _____	_____

### Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: \_\_\_\_\_  
Asthma: (circle) YES NO \_\_\_\_\_

### Response for reaction to all other allergies: Give prompt treatment if the student has any of the following symptoms:

\_\_\_\_\_

Treatment:

1. Administer: \_\_\_\_\_
2. Contact: \_\_\_\_\_
3. Other: \_\_\_\_\_

Healthcare Provider Name (printed): \_\_\_\_\_ MD DO APN PA Date: \_\_\_\_\_  
Healthcare Provider Name (signature): \_\_\_\_\_ Phone: \_\_\_\_\_

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_