Educational Service Center of Medina County
"Stepping Up to Excellence"

Student Photo ID

Food Allergy: Emergency Action Plan

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name:	**Phone (Family):**
Address:	
Emergency Number:	
Physician:	**RN:**
Emergency Medication Location:	

Allergy to: _____

Weight: _____ **lbs.** **Asthma:** _____ **Yes (higher risk for a severe reaction)** _____ **No**

Extremely reactive to the following foods:

_____ **Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.**

_____ **Give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.**

1. 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

Treatment:
1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911.
3. Begin monitoring.
4. Give additional medications (if ordered):
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

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

Treatment:
1. GIVE ANTIHISTAMINE.
2. If symptoms progress (see above), USE EPINEPHRINE.
3. Begin monitoring.

MEDICATIONS/DOSES

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

RN _____ Date _____

MEDICAL REVIEW

I have reviewed the attached Emergency Action Plan (EAP) for _____, AND:

_____ I approve the EAP as written.

_____ I approve the EAP with the attached amendments.

_____ I do <u>not</u> approve of the EAP as written, and substitute orders are attached.

Physician _____ Date _____

OTHER RECOMMENDATIONS

_____

_____

_____

_____

_____

_____

_____

_____

Copies to:

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other _____