

# FOOD ALLERGY ACTION PLAN

Saint Thomas the Apostle School

School Year \_\_\_\_\_

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic: Yes\* \_\_\_\_\_ No \_\_\_\_\_ \* higher risk for severe symptoms

## STEP 1: TREATMENT

<u>SYMPTOMS:</u>	<u>Epinephrine</u>	<u>Antihistamine</u>
• If a food allergen is ingested but, <i>no symptoms</i> :	_____	_____
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	_____	_____
• Skin: Hives, itchy rash, swelling of face or extremities	_____	_____
• Gastrointestinal: Nausea, abdominal cramps, vomiting, diarrhea	_____	_____
• Throat* Tightening of throat, hoarseness, hacking cough	_____	_____
• Lungs* Shortness of breath, repetitive coughing, wheezing	_____	_____
• Heart* Weak or thread pulse, low blood pressure, fainting, pale/blueness of skin	_____	_____
• Other* _____	_____	_____
• If reaction is progressing (several of the above areas affected), give:	_____	_____

\*Potentially life-threatening. The severity of symptoms can quickly change.

### DOSAGE

**Epinephrine:** School Nurse/Delegate inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg

**Antihistamine:** School Nurse give \_\_\_\_\_  
medication/dose/route

**Other:** School Nurse give \_\_\_\_\_  
medication/dose/route

### SELF-ADMINISTRATION BY STUDENT

\_\_\_\_\_ I authorize this student to carry on him and self-administer the single dose auto-injector medication that I have prescribed above in the event of an anaphylactic reaction during school hours.

This authorization for treatment is in effect for the school year for which it is granted and must be renewed for each subsequent school year.

## STEP 2: EMERGENCY CALLS

1. Call 911 or Bloomfield Rescue Squad. State that an allergic reaction has been treated and that additional epinephrine may be needed.
2. Health Care Provider \_\_\_\_\_ Phone: \_\_\_\_\_
3. Parent/Guardian \_\_\_\_\_ Phone Number(s): \_\_\_\_\_
4. Emergency Contacts: Name/Relationship \_\_\_\_\_ Phone Numbers(s) \_\_\_\_\_
  - a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_
  - b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Even if parent/Guardian cannot be reached, do not hesitate to medicate or take child to medical facility.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Health Care Provider Signature/Stamp (required) \_\_\_\_\_

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Dear Parent/Guardian,

Your child has been identified as having a potentially life-threatening food allergy that may require the emergency use of epinephrine while at school. Please review the options below with your child's HCP. Chose one option and complete and sign. If authorization is given for the School Nurse/delegate to administer emergency epinephrine or if the child is capable and approved by their HCP to self-administer, the **Food Allergy Action Plan** must also be completed.

**Parent/Guardian Authorization for the Emergency Administration of Medication by the School Nurse or Delegate**

I authorize the school nurse, and /or a person delegated by the school nurse when the school nurse is not available, to administer the pre-filled, single dose auto-injector mechanism containing epinephrine as prescribed by my child's health care provider on the **Food Allergy Action Plan** (reverse side) to my child, \_\_\_\_\_, if my child is experiencing symptoms of anaphylaxis and does not have the capability for self-administration of this medication.

I am aware that the school nurse does not accompany students on class field trips and that if my child does not have the capability of self-administration of this medication, we (parents/guardians) are responsible for the administration of this medication if required during these trips.

I understand that *Saint Thomas the Apostle School* shall incur no liability as a result of any injury arising from the administration of the prescribed emergency medication to my child and that we (parents/guardians) shall indemnify and hold harmless *Saint Thomas the Apostle School*, its employees or agents and the school nurse against any claims resulting from the administration of this medication to my child.

**I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Parent/Guardian Authorization for Self-Administration of Epinephrine by Student**

My child, \_\_\_\_\_, has been trained in procedure and is capable of self-administration of the pre-filled, single dose auto-injector mechanism containing epinephrine prescribed by my child's health care provider on the **Food Allergy Action Plan** (reverse side) in the event that he/she is experiencing signs of anaphylaxis. I understand that my child is responsible for carrying this medication and having it readily available if needed at school and on class field trips.

I understand and agree that *Saint Thomas the Apostle School*, shall incur no liability as a result of any injury arising from the self-administration of a pre-filled, single dose auto-injector mechanism containing epinephrine by my child and that we (parents/guardians) shall indemnify and hold harmless *Saint Thomas the Apostle School*, its employees or agents and the school nurse against any claims arising out of the self-administration of this medication by my child.

**I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Parent/Guardian Declination Statement for Use of Emergency Epinephrine**

I do not authorize the school nurse and /or delegate to administer emergency epinephrine to my child, \_\_\_\_\_, in the event that my child is experiencing signs of anaphylaxis. I understand that in the event of an anaphylactic emergency the school nurse or principal will contact 911 and that my child will be transported to the nearest medical facility for treatment, and that I will be notified as soon as possible that an anaphylactic reaction has occurred.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date