

Food Allergy

Student: _____ Grade: _____ DOB: _____

Asthmatic: Yes No (increased risk for severe reactions) Allergens: _____

Mother: _____ Home #: _____ Work # _____ Cell #: _____

Father: _____ Home #: _____ Work # _____ Cell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THE FOLLOWING:

- ✓ MOUTH Itching and swelling of lips, tongue or mouth, mouth "feels hot"
- ✓ THROAT Itching, tightness in throat, hoarseness, cough
- ✓ SKIN Hives, itchy rash, swelling of face and extremities
- ✓ STOMACH Nausea, abdominal cramps, vomiting, diarrhea
- ✓ LUNG Shortness of breath, repetitive cough, wheezing
- ✓ HEART "Thready pulse," "passing out"

**THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY
- IT IS IMPORTANT THAT TREATMENT IS GIVEN IMMEDIATELY.**

STAFF MEMBERS INSTRUCTED: Classroom Teacher(s) Special Area Teacher(s) Administration
 Support Staff Transportation Staff

TREATMENT: Rinse area with water if appropriate.

Treatment should be initiated: with symptoms without waiting for symptoms

Benadryl ordered: Yes No Give _____ (dose) Benadryl per provider's orders

Call School Nurse. Call parent / guardian if off school grounds.

Epinephrine ordered: Yes No Special Instructions: _____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Child will be transported to Guadalupe Valley Hospital. Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: Medication available on bus Medication is NOT available on bus Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

Copy provided to Parent Copy sent to the Healthcare Provider

Parent/Guardian Signature: _____ Date: _____

Doctor's/Health Care Provider Signature: _____ Date: _____

This plan is in effect for the current school year and summer school as needed.