Dear Parent/Guardian,

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.

STUDENT NAME:	**DATE OF BIRTH:**
SCHOOL:	**GRADE:**

PREVENTION & EMERGENCY RESPONSE PLAN
FOR STUDENTS WITH LIFE-THREATENING ALLERGIES

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

Student has a life-threatening or severe allergy to:

INGESTION (FOOD): _____

INHALATION: _____

SKIN CONTACT: _____

INJECTION (STING/BITE): _____

ACTION PLAN for life-threatening allergic reaction:

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

Cardiovascular: thready pulse, fainting, cyanosis, pale

Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea

General: panic, sudden fatigue, chills, fear of impending doom

Mouth - itching, tingling, or swelling of the lips, tongue, or mouth

Respiratory: shortness of breath, repetitive coughing, wheezing

Skin: hives, itchy rash, swelling about face or extremities

Throat: feeling tightness in the throat, hoarseness, hacking cough

Other: _____

Treatment: 1. Administer epinephrine _____

(dosage/route/interval: Ex. Epi-Pen Jr. IM with repeat in 20 minutes for continued symptoms)

2. Call 911

3. Continue with monitoring by the nurse until EMS arrives.

4. Other: _____

Other allergies: _____

Asthma (circle) YES NO

Response for reaction to all other allergens:

Give prompt treatment if the student has symptoms of any of the following:

1. Administer: _____

(dosage/route/interval: Ex. 25mg diphenhydramine PO)

2. Contact: _____

3. Other: _____

Healthcare Provider: _____

(printed name)

Heathcare Provider: _____

(signature)

Date: _____

Phone: _____

Prevention for exposure to known food allergies

USDA regulation 7CFR Part 15B requires substitution or modification in school meals for students with diagnosed food allergies, which are life-threatening. This requires physician approval.

Foods to omit:	**Substitutions:**
☐ Eggs	
☐ Whole	
☐ Recipe Ingredient	
☐ Dairy	
☐ Milk	
☐ Cheese	
☐ Whey	
☐ Recipe Ingredient	
☐ Nuts	
☐ Whole/partial	
☐ Tree Nut	
☐ Oil	
☐ Wheat	
☐ Gluten	
☐ Recipe Ingredient	
☐ Trace Amount	

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: _____ Contact: _____

DRAFT