Student Health Services

Food Allergy Care Plan

Student's Name ___________________________ DOB: ___________ Teacher______________________

School________________________________ Grade_______________ (*Please attach picture to Care Plan)

ALLERGY TO: ____

□ ***Box checked indicates a severe food allergy which may lead to anaphylaxis.***

Asthmatic Yes*□ No□ *Higher risk of severe reaction *Inhaler at school? Yes___ No ___ Carries___

***Fulton County School Nutrition Program cannot guarantee that food products served in school cafeterias were not processed in plants that also process nut products.**

STEP 1: TREATMENT

Symptoms:	Give Checked Medication**: **(To be determined by physician authorizing treatment)
If a food allergen has been ingested, but *no symptoms*:	□Epinephrine □ Antihistamine
Mouth* Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine □ Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	□Epinephrine □ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine □ Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	□Epinephrine □ Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	□Epinephrine □ Antihistamine
Heart*: Thready pulse, low blood pressure, fainting, pale, blueness	□Epinephrine □ Antihistamine
Other* ____	□Epinephrine □ Antihistamine
If reaction is progressing (several of the above areas affected),	□Epinephrine □ Antihistamine

***Food Allergy is potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for administration instructions)____

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

****IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace Epinephrine in anaphylaxis.***

STEP 2: EMERGENCY CALLS

1. Call 911 or Rescue Squad: ________________________.
*State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Physician's Full Name: ____ Office Phone:_______________________
3. Emergency contacts: Name/Relationship and Phone Number(s)
a. ____ 1.__________________________ 2. ________________________
b. ____ 1.__________________________ 2. ________________________
c. ____ 1.__________________________ 2. ________________________

Parent/Guardian Signature____Date_____________________

Physician Name (***print legibly***) __________________________ Signature_____________________________ Date__________
(Physician's signature required)

Date Received: _________ Cluster Nurse/Special Education Nurse Signature:______________________________