HARVESTCHRISTIANACADEMY

SEVERE FOOD ALLERGY CARE PLAN

STUDENT NAME: _____**D.O.B:** _____**Grade:**_____

ALLERGY TO: _____

EMERGENCY PLAN

Asthmatic? No Yes - Higher risk for severe reaction

STEP 1: TREATMENT of Symptoms	**Give Selected 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 †** Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine ¨ Antihistamine
• Other †	Epinephrine ¨ Antihistamine
• If reaction is progressing in several of the above areas DO NOT HESITATE TO GIVE:	Epinephrine ¨ Antihistamine

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

STEP 2: CALL 911 if Epi pen is administered

STEP 3: CALL Emergency Contact:

1. Name: _____Relationship:_____ Phone: _____

2. Name: _____Relationship:_____ Phone: _____

3. Physician Name: _____ Phone: _____

Emergency Medications:

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr.
(This student is authorized to self-carry/self-administer an Epinephrine Auto-injector Yes No)

Antihistamine: _____ Dose_____ Route_____

Other: _____ Dose _____Route_____

**********Please fill out page 2 **********

DAILY ALLERGY MANAGEMENT PLAN

Classroom:

O Student is allowed to eat only those foods approved and/or provided by parent
O Middle or high school student is capable of making his/her own food choices
O Alternative snacks will be provided by parent/guardian to be kept in classroom
O Parent/guardian should be advised of any planned parties and/or projects involving food as early as possible

Cafeteria:

O No restrictions
O Student will sit at a designated allergen-aware lunchroom table
O Lunchroom supervisor should be alerted to the student's allergy

Field Trip Procedures – EpiPen should accompany student during any school related off campus activities

• Certified staff member will review care plan and use of emergency medications prior to trip
• Parent/guardian should be advised of any planned field trips and allowed to accompany if possible

Student Considerations:

• Student is able to recognize signs and symptoms of exposure to allergen O Yes O No

Comments Special Instructions: _____

AUTHORIZATIONS

_____ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that _____ should not carry his/her medication by him/herself.

Physician Signature: _____Date:_____

Parent/Guardian Authorization:

• I request this medication be administered as ordered by the student's licensed health care provider.
• I give Health Services staff permission to communicate with the health care provider about this medication.
• I understand that these medications may be administered by a certified staff member who has reviewed this care plan and the use of emergency medication.
• I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
• I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. *Expired medication can not be administered!*
• Medication must be in the original prescription container with instructions as noted by above health care provider.
• It is recommended that an additional EpiPen be kept in the health office if my child is authorized to self-carry.

Parent/Guardian Signature: _____Date:_____