Trumbull Public Schools

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: ______________________________ **D.O.B.:** ___/___/___

Allergy to: ______________________________

Weight: ________ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: ______________________________

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ______________________________

Antihistamine (brand and dose): ______________________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

______________________ ________ ______________________ ________

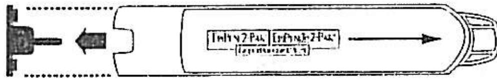
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

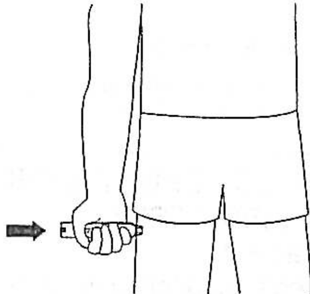
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



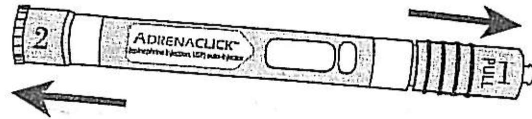
- Hold orange tip near outer thigh (always apply to thigh)

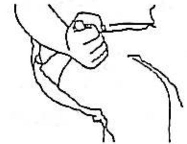


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
  Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

DEY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak™ are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_________) Doctor: _______________ (H)Phone: (___) _____-_________

Parent/Guardian: ______________________________ Dad (C)Phone: (___) _____-_________

Mom(C)Phone(____)___-_________

Other Emergency Contacts

Name/Relationship: ______________________________ Phone: (___) _____-_________

Name/Relationship: ______________________________ Phone: (___) _____-_________

Connecticut State Law requires:

1. The written order of an MD, OD. DDS. APRN, or a PA for prescription and non-prescription medications.
2. Written authorization from the parent/guardian for medications, prescription and non-prescription, to be administered by school personnel.
3. Medication must be received and stored in the original container.
4. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent/guardian or other responsible adult.
5. No more than a 45 day supply of medication may be left at school.
6. Inhalant medications may be self-administered at all grade levels with the approval of the school nurse.
7. Self-administration must be authorized by the MD or authorized prescriber and parent/guardian.

This portion to be completed by Parent or Legal Guardian

I hereby give my permission for my child to receive the medication ordered by a licensed prescriber, recognized by the State of Connecticut·

Medication is to be administered by:

- School Nurse, teacher or principal trained in the administration of the medication.
- Child may self-administer with approval of licensed prescriber and School Nurse.

Please check:

I request the medication be administered on shortened school days. • Yes • No

I request the medication be administered on field trips. • Yes • No PARENT SIGNATURE______________________________