

# SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

## FOOD ALLERGY Action Plan –Food Allergy

**Confidential**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone # Work \_\_\_\_\_ Home # \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Family member/Friend, aware of child's condition. Name \_\_\_\_\_ Phone# \_\_\_\_\_

Asthmatic \* Yes  (\* =High risk for severe reaction) No

Food allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

**Child MUST sit at allergy free table:**  yes  no Is Epi-pen/Benadryl needed on the bus? \_\_\_yes \_\_\_no

*Please tell us what you want us to do in case of an allergic reaction at school.*

*(Please check all that apply)*

**Symptoms:**

**Give Checked Medication:**

If contact with that food, but NO symptoms:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>Mouth:</b> itching, tingling or swelling of lips, tongue, mouth:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>*Throat:</b> Tightening of throat, hoarseness, hacking cough:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>*Lung:</b> Shortness of breath, repetitive coughing, wheezing:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>*Heart:</b> Fainting, pale, blueness, weak or thready pulse, low blood pressure:	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<b>*other:</b> _____	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected)	use <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

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

Notify parent by:  Send note home  Call parent by phone

Allow to rest for \_\_\_\_\_ minutes.

Call 911 if: \_\_\_\_\_

Other/Comments: \_\_\_\_\_

**(If medication is needed at school, and/or field trips/extracurricular activities, you must have a supply of the medication and the permission form signed by the parent and your child's doctor on file for this school year.)**

\*\*\* Is medication required on the bus? **YES or NO** \*\*\*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date of review \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Susan Resch, RN, BSN at [sresch@newlondon.k12.wi.us](mailto:sresch@newlondon.k12.wi.us). If medication is needed for this concern, you must also fill out a medication consent form. Thank you.