EVSC
Evansville Vanderbourgh School Corporation

# Food Allergy Action Plan

PLACE CHILD'S PICTURE HERE

Student's Name:_____ D.O.B._____ Teacher:_____

**ALLERGY TO:** _____

□ A special table for lunch/snacks is requested.

**ALLERGIC REACTION**

**Any of these symptoms can represent an allergic reaction:**

**Mouth**: itching and swelling of the lips, tongue or mouth
**Skin:** hives, swelling of the face or extremities
**Gut**: nausea, abdominal pain, cramps, vomiting, diarrhea
**Throat**: tightening of throat, hoarseness, hacking cough
**Lungs**: shortness of breath, repetitive cough, wheezing
**Heart**: weak or thready pulse, low blood pressure, fainting, paleness, blue color
**Other:**_____

**TREATMENT for ALLERGIC REACTION**

**1. Injectable epinephrine (check one)**
□ EpiPen® □ EpiPen Jr ®
□ Twinject ™ 0.3mg □ Twinject™ 0.15 mg

**2. Antihistamine**
□ Benadryl _____
□ Other _____

**3. Other**_____

**4. Call 911.** State that an allergic reaction has occurred and epinephrine has been given.

**5. Call Emergency Contacts (see below)**

**SUSPICIOUS ALLERGIC REACTION**

**Symptoms**: itchy rash or a few hives

**TREATMENT for SUSPICIOUS REACTION**

**1. Antihistamine**
□ Benadryl_____
□ Other_____

**2. Call Emergency Contacts (see below)**

**Emergency Contacts:**

| **1. Name/Relationship** | **Phone Number(s)** | **Phone Numbers(s)** |
|---|---|---|
| a._____ | _____ | _____ |
| b._____ | _____ | _____ |
| c._____ | _____ | _____ |

***Even if parent/guardian cannot be reached, do not hesitate to medicate or call 911.***

**2. Dr.** _____ **at** _____.
*(Doctor's name)* *(Doctor's phone number)*

□ The school may post this form in a visible location.

□ If the patient presents to the emergency department, please monitor the patient for a biphasic reaction for at least _____ hours.

□ Two doses of Epinephrine should be kept at school in case a repeat dose is needed.

□ The student is capable and has been instructed in the proper method of self administering the medications named above and may carry the medicines during school hours.

| *Physician/Provider Signature* | *Parent Signature* | *Principal Signature* |
|---|---|---|
| *Date:*_____ | *Date:*_____ | *Date:*_____ |

TRAINED STAFF MEMBERS

1. _____ Room_____

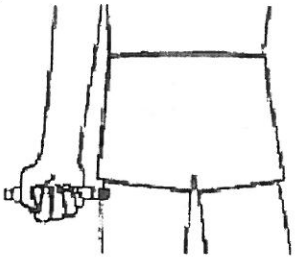
2. _____ Room_____

3. _____ Room_____

## EpiPen® and EpiPen® Jr. Directions

1. Pull off gray activation cap.

2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds

## Twinject® 0.3mg and Twinject® 0.15 mg Directions

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

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

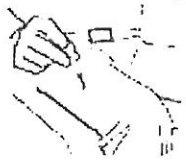
**SECOND DOSE ADMINISTRATION:**

If symptoms don't improve after 10 minutes, administer second dose:

1. Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

2. Slide yellow collar off plunger.

3. Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

# AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION CONCERNING MY CHILD'S ALLERGIES

**Name of Child:** _____

I authorize any doctor/health care provider caring for my child to release, use and exchange any information related to my child's allergies and the treatment of my child's allergies to the nurses, teachers, administrators, cafeteria personnel and other personnel from my child's school.

I understand that I may revoke this Authorization at any time, but that I cannot revoke my authorization as to disclosures that have already been made. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed, to the extent to which it relates only to non-emergency situations.

To revoke this Authorization, I understand I must contact, in writing, the doctor(s)/health care provider(s) caring for my child and _____ at my child's school.

**Authorization and Signature:** I authorize the release of my child's confidential health information as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions set forth above. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Indiana law which prohibits redisclosure or other laws that limit the use and/or disclosure of my child's confidential health information.

I have read this Authorization. I understand that by signing this form, I am authorizing the use and/or disclosure of my child's confidential health care information.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name