Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME:	DATE OF BIRTH:
SCHOOL:	GRADE:

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- ☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
- ☐ General: panic, sudden fatigue, chills, fear of impending doom
- ☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth
- ☐ Respiratory: shortness of breath, repetitive coughing, wheezing
- ☐ Skin: hives, itchy rash, swelling about face or extremities
- ☐ Throat: feeling tightness in the throat, hoarseness, hacking cough
- ☐ Other: _____

Treatment:

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:	Substitutions:	Foods to omit:	Substitutions:
☐ Eggs		☐ Milk	
☐ Whole	_____	☐ Milk	_____
☐ Ingredient in Recipe	_____	☐ Cheese	_____
☐ Other	_____	☐ Whey	_____
☐ Wheat	_____	☐ Ingredient in Recipe	_____
☐ Gluten	_____	☐ Other	_____
☐ Trace Amount	_____	☐ Nuts	_____
☐ Ingredient in Recipe	_____	☐ Tree Nut	_____
☐ Soy	_____	☐ Peanut	_____
☐ Soy Lecithin	_____	☐ Other	_____
☐ Oil	_____	☐ Fish	_____
☐ Isolated Soy Protein	_____	☐ Shellfish	_____
☐ Ingredient in Recipe	_____	☐ Other Not Included on List	_____
☐ Other	_____		

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____

Asthma: (circle) YES NO _____

Response for reaction to all other allergens: *Give prompt treatment if the student has any of the following symptoms:*

_____

_____

Treatment:

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO APN PA Date: _____

Healthcare Provider Name (signature): _____ Phone: _____

Autorizo a la enfermera escolar a implementar este plan. Yo entregaré la medicación en el envase original y notificaré a la enfermera escolar en caso de que haya cualquier cambio. Comprendo que el personal escolar relevante será notificado de las alergias de mi hijo y que yo tendré que trabajar con la supervisora de nutrición escolar en lo relacionado con las alergias alimentarias.

Firma del padre/madre: _____ **Fecha:** _____ **Teléfono:** _____