PLAN OF CARE
Food Allergy

Student:____
Grade_____________

Asthmatic: YES* ☐ **NO** ☐ ***High Risk For Severe Reaction**

***FOOD ALLERGY TO*: ____**	
SIGNS OF AN ALLERGIC REACTION: **(ALL CAN PROGRESS TO LIFE-THREATENING SITUATION)**	
• MOUTH	• Itching & Swelling of lips, tongue, or mouth
• THROAT*	• Itching, and/or sense of tightness in throat, hoarseness, and hacking cough
• SKIN	• Hives, itchy rash, and/or swelling of face or extremities
• GUT	• Nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG*	• Short of breath, persistent cough, and/or wheezing
• HEART*	• “Thready” pulse, passing out

IF SYMPTOMS ARE *MILD* AND ARE:	**DO THIS:**	
1.	GIVE MEDICATION:	
2.	CONTACT:	
3.	1. NAME:	PHONE:
4.	2. NAME	PHONE:
5.	3. NAME:	PHONE:

IF CONDITION DOES NOT IMPROVE WITHIN 10 MINUTES OR WORSENS, FOLLOW STEPS BELOW

IF SYMPTOMS ARE *SEVERE* AND ARE:	**DO THIS IMMEDIATELY**:	
1.	GIVE MEDICATION:	
2.	CONTACT:	
3.	1. **911 OR RESCUE SQUAD**	
4.	2. NAME:	PHONE:
5.	3. NAME:	PHONE:

Trained/Reviewed use of Epi-Pen:	**Student may carry Epi-Pen with them while at school or while at a school function after school hours.**
1. ____________________________	
2. ____________________________	______________________________ **(Parent/Guardian Signature)**
3. ____________________________	______________________________ **(Principal Signature)**
4. ____________________________	______________________________ **(School Nurse/Aide Signature)**

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(Signature of Parent/Guardian) **(Date)**