Plan of Care – Food Allergy

Student: _____ Grade: _____

Asthmatic: ☐ NO ☐ YES - 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:

Student may carry Epi-Pen with them while at school or while at a school function after school hours.

❖ _____
(Parent/Guardian Signature)

❖ _____
(Principal Signature)

❖ _____
(School Nurse/Aide Signature)

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

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Documentation of Participation and Acknowledgement of Plan Trained/Reviewed Use of Emergency Medications:		
Title	**Name**	**Date**
Principal		
Assistant Principal		
Nurse		
Clinic Backup		
Clinic Backup		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Other		
Other		