Woodland School District 50

FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Name:_____ DOB:_____

Teacher:_____ Grade:_____

ALLERGY TO:_____ Weight:_____

Asthma: _____ Yes (higher risk for severe reaction) _____ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.30 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN SIGNATURE/DATE/PHONE **PHYSICIAN/HCP SIGNATURE/DATE/PHONE**

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911	OTHER EMERGENCY CONTACTS
RESCUE SQUAD: _____	NAME/RELATIONSHIP: _____ PHONE: _____
DOCTOR: _____ PHONE: _____	NAME/RELATIONSHIP: _____ PHONE: _____
PARENT/GUARDIAN: _____ PHONE: _____	NAME/RELATIONSHIP: _____ PHONE: _____

(Self Carry and Self Administer apply only for EpiPen & Quick-relief Inhaler).

AS NEEDED ☐ SELF CARRY ☐ SELF ADMINISTER ☐

FOR SELF CARRY/ADMINISTER ONLY

I certify that _____ is permitted to self administer the medication above. He/she understands the use for the medication and the necessity to report to school staff any unusual side effects. He/she is able to self carry and self administer the above independently. I indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of self carry by the student.

FOR SELF CARRY ONLY

I certify that _____ is permitted to self carry, but not self administer, the medication above. I indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the student's self carry of the medication.

****ALL MEDICATIONS, BOTH OVER THE COUNTER OR PRESCRIPTION, NEED A PARENT AND A PHYSICIAN SIGNATURE.** All medications are required to be delivered by a parent/guardian, with the prescription label. All medications will be discarded 2 weeks after the last school day if not picked up. A new completed Medication Authorization Form is required at the beginning of every school year or when there is a change in the student's medical needs as indicated on this form.**