Food Allergy Action Plan

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

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

DOCTOR OFFICE STAMP

COLTS NECK TOWNSHIP SCHOOLS
Colts Neck, New Jersey

Administration of Epinephrine

This correspondence will serve as acknowledgement of the need for the administration of epinephrine to your child_____
Child's full name (print)
in case of emergency and of your request that the school personnel, including the nurse and other designated school employees administer epinephrine to your child in case of emergency.

This correspondence will further serve as notification to you pursuant to NJSA 18A:40-12.5 and NJSA 18A:40-12.6, that if the procedures specified in the aforementioned statutes are followed, the Colts Neck Township Schools and its employees shall have no liability for injuries arising from the administration of epinephrine to your child and that you agree to indemnify and hold harmless the school and the school district from all claims arising from the administration of epinephrine by school personnel to your child.

I agree to immediately contact the school nurse if any changes occur to this order and/or my child's condition changes. I agree to replace the EpiPen immediately if it is used or reaches its expiration date.

Acknowledged and Agreed

_____
Parent/Guardian Name (Print)

_____
Parent/Guardian Signature

_____
Date

Colts Neck Township Schools
FOOD ALLERGY FORM

Student's Name_____
Homeroom Teacher_____

Dear Parents,

Please list any dietary restrictions or food allergies that your child has:
_____

If your child has a food allergy, please complete the following:

How long has your child had a food allergy?_____
How many reactions has your child had?_____
What symptoms did your child experience during a reaction? _____
_____
Has your child ever been treated with Benadryl or an EpiPen for an allergic reaction? _____
If yes, please explain_____
_____

Please check one of the following options if your child has a peanut allergy:

_____I do not want my child to sit at a peanut-free table.
_____I would like my child to sit at a peanut-free table. (In order to maintain the safety of the peanut-free table, children will not be able to purchase food from the cafeteria and visitors from other tables will not be permitted.).

Your child's safety is of the utmost importance to us. We strongly recommend that any child with a life threatening food allergy eat only foods brought in from home. Should you allow your child to purchase any item from our school cafeteria, please exercise caution and good judgment. It is important to note, however, that Sodexho Food Services may have food substitutions at any point that deviate from their published menu. These substitutions may contain potentially harmful allergens. Should you need clarification regarding the ingredients found in any food product, please contact Lisa Elsinger, Food Service Manager at 732-946-0055 ext. 4754.

I give permission for this information to be shared with Colts Neck Township employees and the class parents in my child's homeroom.

Parent/Guardian Signature_____ Date_____