# LITTLE CHUTE AREA SCHOOL DISTRICT
## *School Health Services*
## FOOD ALLERGY HEALTH PLAN

Name:_____ D.O.B:_____ Grade:_____

Allergic to:_____ Weight:_____ Provider: _____

Does the student have asthma? ◯ Yes (higher risk for a severe reaction) ◯ No

☐ If checked, give epinephrine immediately if the allergen was **eaten**, even if there are no symptoms

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

| | SEVERE SYMPTOMS |
|---|---|
| LUNG | Short of Breath, wheezing, repetitive cough |
| HEART | Pale, blue, faint, weak pulse, dizzy |
| THROAT | Tight, hoarse, trouble breathing/swallowing |
| MOUTH | Significant swelling of the tongue and/or lips |
| SKIN | Many hives over body, widespread redness |
| GUT | Repetitive vomiting or severe diarrhea |
| OTHER | Feeling something bad is about to happen, anxiety, confusion<br>* OR a combination of mild or severe symptoms from different body areas. |

**EMERGENCY PROCEDURE**

1. **For any of the listed SEVERE symptoms, INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell the rescue squad epinephrine was given. Request ambulance with epinephrine.
3. Consider giving additional medications (following or with the epinephrine): Antihistamine, Inhaler (bronchodilator) if asthma
4. Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, a second dose of epinephrine can be given 5 minutes or more after the last dose.
6. Alert emergency contacts (parent/guardian).

| | MILD SYMPTOMS |
|---|---|
| NOSE | Itchy/runny nose, sneezing |
| MOUTH | Itchy mouth |
| SKIN | A few hives, mild itch |
| GUT | Mild nausea/discomfort |

**PROCEDURE**

1. **When in doubt, give epinephrine.**
2. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN.**
3. Stay with student; alert emergency contacts.
4. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE**.

**EMERGENCY MEDICATIONS:**

**Epinephrine:** Inject intramuscularly (circle one) EpiPen EpiPen Jr. Auvi-Q 0.3 mg Auvi-Q 0.15 mg

Side effects:_____

**Antihistamine name**: _____ Dose:_____ Route: _____

Side effects:_____

**Other (ex. inhaler)**: medication/dose/route _____

☐ The student is authorized to self-carry and self-administer the above medications.

_____

Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips. Please note that for the safety of the student, all staff members will be made aware of the student's allergy.