

Student's Name _____ D.O.B. _____ Teacher _____
School _____ Grade _____ (*Please attach picture to Care Plan)

ALLERGY TO: _____

Box checked indicates a severe food allergy which may lead to anaphylaxis.

Asthmatic Yes* No Higher risk of severe reaction *Inhaler at school? Yes ___ No ___ Carries ___

***Fulton County School Nutrition Program cannot guarantee that food products served in school cafeterias were not processed in plants that also process nut products.**

STEP 1: TREATMENT

Symptoms:

Give Checked Medication**:

** (To be determined by physician authorizing treatment)

- | | | |
|---|--------------------------------------|--|
| If a food allergen has been ingested, but <i>no symptoms</i> : | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Mouth* Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Skin: Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Gut: Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Throat*: Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Lung*: Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Heart*: Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Other* _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| If reaction is progressing (several of the above areas affected), | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

***Food Allergy is potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for administration 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. Physician's Full Name: _____ Office Phone: _____

3. Emergency contacts: Name/Relationship Phone Number(s)

- | | | |
|----------|----------|----------|
| a. _____ | 1. _____ | 2. _____ |
| b. _____ | 1. _____ | 2. _____ |
| c. _____ | 1. _____ | 2) _____ |

Parent/Guardian Signature _____ Date _____

Physician Name (*print legibly*) _____ Signature _____ Date _____
(Physician's signature required)

Received Date: _____ Cluster Nurse Signature/Special Education Nurse: _____