Food Allergy Action Plan

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

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*:		☐ EpiPen	☑ Antihistamine	
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine	
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☑ EpiPen	☑ Antihistamine	
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine	
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine	
▪ Lung †	Shortness of breath, repetitive coughing wheezing	☐ EpiPen	☐ Antihistamine	
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☑ Antihistamine	
▪ Other †_____		☐ EpiPen	☐ Antihistamine	
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine	

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ 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. _____ at _____

3. Emergency contacts:

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

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

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

School Name		EMERGENCY CARE PLAN OTHER
School Address		
School Address		

Student Name:		Student ID:		Date:	
School:	Grade	Birthdate:		Primary Language:	

- The school district intends to use the requested information to provide your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed, it may result in an incomplete health and safety plan for your child.
- Medications are not administered at school without physician and parent signatures.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision 2)

HEALTH CARE INFORMATION

Health Care Provider:		Phone:	
Hospital of Choice:		Phone:	

CONTACT INFORMATION

Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Home Phone:				

MEDICAL DIAGNOSIS

POSSIBLE EMERGENCY SYMPTOMS

ALLERGIES

EMERGENCY PLAN OF ACTION

- Accompany to heath office immediately or call: _____
- Health office to call 911 under the following conditions:
- Notify parents of situation.

SPECIAL INSTRUCTIONS

Field Trip:

Physician Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____
Parent Signature: _____ Date: _____

School Name		EMERGENCY CARE PLAN DIABETES
School Address		
School Address		

Student Name:				Student ID:		Date:	
School:		Grade		Birthdate:		Primary Language:	

- The school district intends to use the requested information to provide your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
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HEALTH CARE INFORMATION

Health Care Provider:		Phone:	
Hospital of Choice:		Phone:	

CONTACT INFORMATION

Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Home Phone:				

Blood sugar target range:		to	

SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR

- ☐ Shaking/trembling
- ☐ Dizziness/difficulty with coordination
- ☐ Irritability
- ☐ Loss of consciousness
- ☐ Sweating
- ☐ Other: _____
- ☐ Pallor
- ☐ Hunger/butterfly feeling
- ☐ Blurred vision
- ☐ Weakness/drowsy
- ☐ Tingling sensation
- ☐ Confusion/disorientation
- ☐ Severe headache
- ☐ Anxious
- ☐ Rapid heat beat

EMERGENCY PLAN OF ACTION

- Must accompany to heath office immediately or call: _____
- If unable to walk to health office, call: _____
- Health office to test and record blood sugar: _____

• **If less than:**		**give**	
• **If more than:**		**give**	

If student is **conscious:**

- **Give snack:**
- If unable to give snack, give glucose gel inside of cheek.
- Recheck blood sugar in 10 minutes and give another snack if needed.
- Notify parents of situation.
- After treatment, the student may resume his/her schedule if blood sugar returns to target range.

If student **is not conscious or is unable to swallow:**

- Call 911 immediately.
- Do not give anything to eat or drink.
- Administer glucagons per MD order *(turn to side as vomiting usually occurs)*.

SPECIAL INSTRUCTIONS

Field Trip:

Physician Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____
Parent Signature: _____ Date: _____

School Name	
School Address	
School Address	

EMERGENCY CARE PLAN
ASTHMA

Student Name:		Student ID:		Date:	
School:		Grade:	Birthdate:	Primary Language:	

- The school district intends to use the requested information to provide your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed, it may result in an incomplete health and safety plan for your child.
- Medications are not administered at school without physician and parent signatures.
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HEALTH CARE INFORMATION

Health Care Provider:		Phone:	
Hospital of Choice:		Phone:	

CONTACT INFORMATION

Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Parent/Guardian	Relationship	Phone #	Phone Type	Primary Language
Home Phone:				

SIGNS AND SYMPTOMS

(GREEN ZONE)—Normal Breathing **Peak flow range** to

- Breathing easy
- Can play, work, and sleep without asthma symptom.

(YELLOW ZONE)—Early Warning (Action Needed) **Peak flow range** to

- Trouble breathing
- Wheezing
- Tight cough
- Difficulty exhaling
- Stomach upset
- Feeling of tightness
- Anxious

ACTION:

- Remain calm (reassure and stay with student).
- Administer medication per MD order:

Medication	Dose	Route	Time	Instructions

- Give room temperature water.
- If no relief of symptoms (5-10 minutes after treatment) **call 911.**

(RED ZONE)—Severe Symptom (Emergency) **Peak flow range** to

- Chest and neck pulled in when breathing.
- Trouble walking and talking.
- Lips or fingernails blue or gray.
- Increase anxiety and confusion.
- Loss of consciousness.

ACTION:

- Take emergency medication.
- If no relief, or no medication available, **call 911 immediately.**
- Notify parents of situation.

SPECIAL INSTRUCTIONS

Field Trip:

Physician Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____
Parent Signature: _____ Date: _____

ASTHMA ACTION PLAN

Name: _____ DOB: _____

PA

Asthma Severity:	Allergies:	Other Triggers:	
☐ Mild intermittent	☐ Dust ☐ Animals	☐ Viral ☐ Weather	☐ AVOID ASTHMA TRIGGERS
☑ Mild persistent	☐ Mold ☐ Pollen	☐ Exercise ☐ Smoke	☐ NO SMOKING IN HOME OR CAR
☐ Moderate persistent	☐ Food: _____	☐ Other:	☐ INHALER TECHNIQUE REVIEWED
☐ Severe persistent	☐ Meds: _____		Height: _____ Weight: _____

1. Green Zone

- Breathing is easy
- Can work and play
- Can sleep at night
- No cough or wheeze

Peak Flow Range _____ to _____
(80%-100% of Personal Best/Predicted)

For physical activity/gym/recess/exposure to triggers take: ☑ Albuterol 2 puffs 10-20 min. before activity or exposure to triggers

Take controller medicine every day - this may include allergy medicine.

Medication	Dose			How Often
☐ Advair	☐ 500/50	☐ 250/50	☐ 100/50	1 puff twice daily
☐ Flovent	☐ 44 mcg	☐ 110 mcg	☐ 220 mcg	____puff twice daily
☐ Pulmicort Respules	☐ 0.25 mg	☐ 0.5 mg		____time(s) per day
☑ Pulmicort Turbuhaler	____puffs			____time(s) per day
☐ QVAR (Beclomethasone)	☐ 40 mcg	☐ 80 mcg		___puffs___time(s) per day
☑ Singulair	☐ 4 mg	☑ 5 mg	☐ 10 mg	daily (preferably evenings)

☐ Additional orders:

2. Yellow Zone — Slow down

- Cold or runny nose
- Coughs during day
- Wheeze or tight chest
- Wake up at night with cough

Peak Flow Range _____ to _____
(50%-79% of Personal Best/Predicted)

Call health care provider if reliever medicine does not last 4 hours, if you are in the Yellow Zone for more than 12-24 hours, or if you need reliever medicines more than 2 times per week.

Keep taking Green Zone controller medicines. Take the following reliever medicines to keep asthma from getting worse.

Medication	Dose			How Often
☐ Albuterol ☐ Nebulizer or ☐ Inhaler	☐ 0.25 ml ☐ 2.5 mg in 3 ml NS (premixed vial) ☐ 2 puffs	☐ 0.5 ml	☐ in 2 ml NS	Every 4 hours
☑ Xopenex	☐ 0.31 mg	☑ 0.63 mg	☐ 1.25 mg	3 times per day

☐ Additional orders:

3. Red Zone — Stop

- Medicine is not helping
- Breathing is hard and fast
- Can't talk well
- Ribs show
- Getting worse
- Coughs continuously

Peak Flow Range _____ to _____
(less than 50% Personal Best/Predicted)

Take these medicines NOW and call your health care provider. Keep taking the Green and Yellow Zone medicines.

Medication	Dose	How Often
☐ Prednisone	_____ mg	2 times daily for 5 days
☐ Prednisone 15 mg/5 ml	_____ mg	2 times daily for 5 days
☐ Pediapred 5 mg/5 ml	_____ mg	2 times daily for 5 days
☐ Increase frequency of Albuterol as above - use every _____ hours		

☐ Additional orders:

If breathing does not improve and you cannot contact your health care provider, go to the emergency room.

Call 911 if:
- fingernails or lips are grey or blue
- you can't get air
- you are worried about being unable to get through next 30 minutes

Other medications: _____

☐ Influenza shot in the fall Return to clinic in: _____ days _____ weeks _____ months _____ year

This form provides consent for school/day care to administer to my child the above medicine as provided by parent or guardian and allows the child to carry the inhaler for which our provider has assessed ability and if approved by the school nurse.

Parent/Guardian Signature Date Emergency parent number(s) for school to contact

Health Care Provider signature Date Clinic phone number