Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME:	DATE OF BIRTH:
SCHOOL:	GRADE:

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
____________	☐	☐	☐	☐
____________	☐	☐	☐	☐
____________	☐	☐	☐	☐
____________	☐	☐	☐	☐

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
☐ General: panic, sudden fatigue, chills, fear of impending doom
☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth
☐ Respiratory: shortness of breath, repetitive coughing, wheezing
☐ Skin: hives, itchy rash, swelling about face or extremities
☐ Throat: feeling tightness in the throat, hoarseness, hacking cough
☐ Other: ____________

Treatment:

1. Administer epinephrine (dosage/route/interval) ____________
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: ____________

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:	Substitutions:
☐ Eggs	
☐ Whole	____________
☐ Ingredient in Recipe	____________
☐ Other	____________
☐ Wheat	____________
☐ Gluten	____________
☐ Trace Amount	____________
☐ Ingredient in Recipe	____________
☐ Soy	____________
☐ Soy Lecithin	____________
☐ Oil	____________
☐ Isolated Soy Protein	____________
☐ Ingredient in Recipe	____________
☐ Other	____________

Foods to omit:	Substitutions:
☐ Milk	
☐ Milk	____________
☐ Cheese	____________
☐ Whey	____________
☐ Ingredient in Recipe	____________
☐ Other	____________
☐ Nuts	____________
☐ Tree Nut	____________
☐ Peanut	____________
☐ Other	____________
☐ Fish	____________
☐ Shellfish	____________
☐ Other Not Included on List	____________

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: ____________
Asthma: (circle) YES NO ____________

Response for reaction to all other allergens: *Give prompt treatment if the student has any of the following symptoms:*

____
____

Treatment:

1. Administer: ____________
2. Contact: ____________
3. Other: ____________

Healthcare Provider Name (printed): ____________ MD DO APN PA Date: ____________
Healthcare Provider Name (signature): ____________ Phone: ____________

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: ____________ **Date:** ____________ **Phone #:** ____________