Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Food Allergy and Anaphylaxis Plan

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Allergy to: _____

Weight: _____ lbs. Asthma: _____ Yes (higher risk for severe reaction) _____ No

Complete if your child is EXTREMELY REACTIVE:

Extremely Reactive to the following foods: _____

THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, **EVEN IF NO SYMPTOMS ARE NOTED.**

For any **SEVERE SYMPTOMS** after suspected or known ingestion:
(one or more of the following)

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, severe diarrhea
Other:	Feeling something bad is about to happen, anxiety, confusion

1. **Inject Epinephrine immediately**
2. **Call 911**
3. Consider giving additional medications:
   a. Antihistamine
   b. Inhaler (if wheezing)
4. Lay person flat with legs elevated.
5. If symptoms don't improve or worsen after 5 minutes, give second dose of epinephrine if available.
6. Alert emergency contacts.

-OVER-

For any **MILD** symptoms from a **SINGLE SYSTEM**:

Nose:	Itchy/runny nose, sneezing
Mouth:	Itchy mouth
Skin:	A few hives, mild itch
Gut:	Mild nausea/discomfort

1. Antihistamine may be given, if ordered by a provider.
2. Stay with person and monitor for changes.
3. If symptoms worsen, give epinephrine if ordered. If given, call 911.
4. Alert emergency contacts.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

Medications/Doses to be given at school:

Epinephrine Brand (Rx label attached): _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM Expiration Date:_____

Antihistamine Brand or Generic:_____

Antihistamine Dose:_____ Expiration Date:_____

Other: (e.g., Inhaler-bronchodilator if wheezing):_____ Exp Date:_____

_____ My child has a mild reaction and if my child would ingest _____ please call parent. .**Medication will not be provided for the school at this time. I understand that if the reaction appears life threatening 911 will be called first.**

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date_____

Physician Information

Print Name of Provider_____ **Clinic Name**_____
Phone Number_____ **Fax Number**_____
Address_____

Signature of Provider_____ **Date**_____

Revised 4/2017