Trousdale County Schools
Food Allergy Action Plan

Photo If Available

Student's Name: _____D.O.B _____

Teacher: _____School: _____

ALLERGIC TO: _____

Asthmatic? ☐**Yes*** ☐**No** ***Higher risk for severe reaction**

♦STEP 1: TREATMENT ♦

		Give Checked Medication**	
		**As determined by physician authorizing treatment	
□	If a food allergen has been ingested, but ***no symptoms***	□ Epinephrine	□ Antihistamine
□	**Mouth-** Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine	□ Antihistamine
□	**Throat-** Itching, throat closing up, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
□	**Gut:** Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□ Antihistamine
□	**Lung**† Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
□	**Heart**† Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
□	**Other**† _____	□ Epinephrine	□ Antihistamine
□	**If reaction is progressing** (several of the above areas affected), give:	□ Epinephrine	□ Antihistamine

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

DOSAGE TO GIVE:

Epinephrine: (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Inject intramuscularly per manufacturer's instructions

Antihistamine: give_____medication/dose/route

Other: give _____ medication/dose/route

**Dosage determined by physician authorizing treatment

- **This student can ☐ can not ☐ carry the epi-pen on his/her person for emergency use.**
- **This student has ☐ has not ☐ been taught to self-administer his/her epi-pen.**
- **This student will ☐ will not ☐ need assistance to administer his/her epi-pen.**

♦STEP 2: EMERGENCY CALLS♦

1. **Call 911**. State that a child is having an anaphylactic reaction, has been treated, and additional Epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Father _____ Home Phone: _____
   Work Phone: _____ Cell Phone: _____

4. Mother: _____ Home Phone: _____
   Work Phone: _____ Cell Phone: _____

5. Emergency contacts to act in behalf of Parents:

Name/Relationship	Phone Number(s)
_____	_____
_____	_____
_____	_____

EVEN IF PARENT/GUARDIAN CAN NOT BE REACHED, DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE CHILD TO A MEDICAL FACILITY! We give permission for our child to be treated as deemed necessary for the condition listed above.

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____
(Required)

Please complete a Special Diet Prescription for Meals at School Form & attach to this document.

Revised 2018

Trousdale County Schools
Special Diet Prescription for Meals at School
Food Allergy or Medical Condition

Name of Student _____ **Age:** _____

Medical Condition/Special Need that restricts the child's diet: _____

Major life activity affected by child's medical condition: _____

☐ **Substitute with any foods not containing** _____.

OR

FOODS TO BE OMITTED	**FOODS TO BE SUBSTITUTED**

Does this student have a feeding tube? ☐ **Yes** ☐ **No**

☐ **This student's only need is texture modification. All foods are allowable.**

If any foods need to be omitted from the soft mechanical diet, please list (ex. all combination foods such as pizza & chili, all leafy vegetables, etc.): _____

Special Diet Prescription: _____

This diet order supersedes all previous orders and will remain in effect until a new order is submitted.

Signature of Physician: _____ **Date:** _____

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