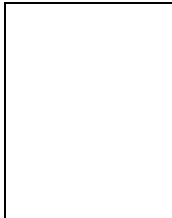


Trousdale County Schools Food Allergy Action Plan



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

Teacher: _____ School: _____

ALLERGIC TO: _____

Asthmatic? Yes* No *Higher risk for severe reaction

Photo
If Available

◆STEP 1: TREATMENT◆

Give Checked Medication**

**As determined by physician authorizing treatment

- | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> If a food allergen has been ingested, but no symptoms <input type="checkbox"/> Mouth- Itching, tingling, or swelling of lips, tongue, mouth <input type="checkbox"/> Throat- Itching, throat closing up, hoarseness, hacking cough <input type="checkbox"/> Gut: Nausea, abdominal cramps, vomiting, diarrhea <input type="checkbox"/> Lung† Shortness of breath, repetitive coughing, wheezing <input type="checkbox"/> Heart† Thready pulse, low blood pressure, fainting, pale, blueness <input type="checkbox"/> Other† _____ <input type="checkbox"/> If reaction is progressing (several of the above areas affected), give: _____ | <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> </table> | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> 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.

**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: _____