

# KENNE DALE ISD

## Food Allergy Action Plan

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_  
 Weight: \_\_\_\_\_ lbs Asthma:  Yes (higher risk for a severe reaction)  No

**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.

**Any SEVERE SYMPTOMS after suspected or known ingestion**

**One or more** of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g. eyes, lids, lips)
- GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications: \*
  - antihistamine
  - Inhaler (bronchodilator) if asthma

\* Antihistamines & Inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis)  
**USE EPINEPHRINE**

**MILD SYMPTOMS ONLY:**

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above) USE EPINEPHRINE  
 Begin monitoring (see box below)

**Medications/Doses**

Epinephrine (brand and dose): \_\_\_\_\_  
 Antihistamine (brand and dose): \_\_\_\_\_  
 Other (e.g. inhaler-bronchodilator if asthmatic): \_\_\_\_\_

<b>Physician's Name</b>	<b>Physician's Phone</b>	<b>Physician Signature (Required)</b>	<b>Date</b>
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I understand that it is my responsibility to renew this form every school year and anytime my child's medical needs change.

\_\_\_\_\_  
 Parent's Signature Parent's Phone Date

**MONITORING**

**Stay with student; alert healthcare professionals and parent.** Tell rescue squad that epinephrine was given; request an ambulance with epinephrine. Note time epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first, if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

**TRAINED STAFF MEMBERS IN THE ADMINISTRATION OF EPINEPHRINE**

1. \_\_\_\_\_ ROOM \_\_\_\_\_ 2. \_\_\_\_\_ ROOM \_\_\_\_\_

The completed form may be faxed to the School Nurse at the student's school.

SCHOOLS	PHONE	FAX
KHS	817-563-8100	817-563-3718
KJHS	817-563-8200	817-483-3655
JAA	817-563-8300	817-483-3628
JFD	817-563-8400	817-483-3653
RFP	817-563-8600	817-483-3638

A NEW FORM IS REQUIRED EVERY SCHOOL YEAR