SCHOOL DISTRICT OF SHIOCTON
N5650 Broad St, P.O. Box 68, Shiocton, WI 54170-0068
(920) 986-3351 ● Fax (920) 986-3291

Food Allergy Emergency Health Plan

Name:_____ D.O.B:_____ Grade/Room:_____

Allergic to:_____ Weight:_____ Provider: _____

Does the student have asthma? [ ] Yes (higher risk for a severe reaction) [ ] No

[ ] If checked, give epinephrine immediately if the allergen was **eaten**, even if there are no symptoms
[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was **likely eaten.**

	SEVERE SYMPTOMS
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 or severe diarrhea
OTHER	Feeling something bad is about to happen, anxiety, confusion * OR a combination of mild or severe symptoms from different body areas.

EMERGENCY PROCEDURE

1. **For any of the listed SEVERE symptoms, INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell the rescue squad epinephrine was given. Request ambulance with epinephrine.
3. Consider giving additional medications (following or with the epinephrine): Antihistamine, Inhaler (bronchodilator) if asthma
4. Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, a second dose of epinephrine can be given 5 minutes or more after the last dose.
6. Alert emergency contacts (parent/guardian).

	MILD SYMPTOMS
NOSE	Itchy/runny nose, sneezing
MOUTH	Itchy mouth
SKIN	A few hives, mild itch
GUT	Mild nausea/discomfort

PROCEDURE

1. **When in doubt, give epinephrine.**
2. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN.**
3. Stay with student; alert emergency contacts.
4. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE**.

EMERGENCY MEDICATIONS

Epinephrine: Inject intramuscularly (circle one):
EpiPen EpiPen Jr. Auvi-Q 0.3 mg Auvi-Q 0.15 mg Adrenaclick 0.15mg Adrenaclick 0.3mg
Side effects:_____ Expiration Date: _____

Antihistamine name: _____ Dose:_____ Route: _____
Side effects:_____ Expiration Date: _____

Other (ex. inhaler): _____ Dose:_____ Route: _____
Side effects: _____ Expiration Date: _____

[ ] The student is authorized to self-carry and self-administer the above medications.

_____

Parent/Guardian Authorization Signature Date **Physician/HCP Authorization Signature Date**

I agree to allow my child to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. Please check: Yes ☐ or No ☐

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips. Please note that for the safety of the student, all staff members will be made aware of the student's allergy. I hereby give my permission to school personnel to give this medication to my child according to the directions stated above and to contact the child's practitioner if necessary. I further agree to hold the Shiocton School District and above person harmless in any and all claims arising from the administration of this medication at school. I agree to notify the school in writing when any change in the above order is necessary.

Revised 03/2020