Food Allergy Action Plan

Place Student's Picture Here

Name: ______________________ D.O.B.: __/__/__

Allergy to: ______________________

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, 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
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ______________________

Antihistamine (brand and dose): ______________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when 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.

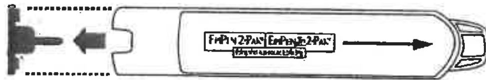
______________________ Parent/Guardian Signature ______ Date ______________________ Physician/Healthcare Provider Signature ______ Date

TURN FORM OVER

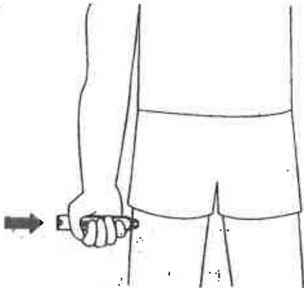
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

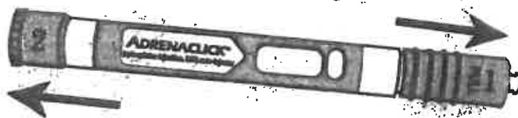
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_________) Doctor:____________________ Phone: (___)_____-_________

Parent/Guardian:______________________________________ Phone: (___)_____-_________

Other Emergency Contacts

Name/Relationship:____________________________________ Phone: (___)_____-_________

Name/Relationship:____________________________________ Phone: (___)_____-_________

Diet Modification Request Form

Modifications are required by The United States Department of Agriculture (USDA) to accommodate a disability. Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. **"Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.**

This form must be completed by a "medical authority" that is authorized by state law to write medical prescriptions: In Iowa this includes only Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Physician's Assistants (PA), or Advanced Registered Nurse Practitioners (ARNP).

Return the completed form to your organization or provider: ______________________
(Head Start, Summer Meal Provider, Day Care, Home Provider, or School)

Participant's Name: ______________________ Birth Date: __________ Grade: __________

Parent/Guardian: ______________________ *(Name)* ______________________ *(Phone or email)*

1) Describe the medical need related to the diet order and "major life activity" **(see above)** affected.
Example: Allergy to peanuts affects ability to breathe.

2) Explain what must be done to accommodate the medical need:

Food(s) or Formula to Omit:	Food(s) or Formula to Substitute:

Complete the back to provide additional details

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed
Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick
Special Feeding Equipment: ☐ Not Applicable ☐ Equipment Needed: ______________________
(Example: large handled spoon, sippy cup, etc.)

Infants under one year of age must receive iron-fortified infant formula or breast milk unless a Diet Modification Request Form is on file.

Licensed prescribing medical professional: ______________________
(Name, print or type) *(Title)*

____
(Signature of medical professional) *(Date)*

The program must make accommodations for disabilities. Accommodation is encouraged for other medical conditions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without direction from a medical professional. This site chooses to offer this nutritionally equivalent product: ______________. Check here if you would like to request the milk substitute listed in place of fluid milk and list the reason for the request. ☐ ______________________
USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ☐

Parent/Guardian signature: ______________________ Date: __________
(To document choices and permission to share with appropriate staff as needed to make accommodations.)

USDA is an equal opportunity employer and provider.

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services 11/2017

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – *Do not serve the items checked below:*	**Serve these items instead:**
Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no Milk based desserts such as ice cream and pudding Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese Cheese baked in products such as a casserole or on meat pizza Cold cheese such as string cheese or sliced cheese on a sandwich Milk in food products such as breads, mashed potatoes, cookies or graham crackers	
Soy - *Do not serve the items checked below:*	**Serve these items instead:**
Protein products extended with soy Processed items cooked in soy oil Food products with soy as one of the first three ingredients Food products with soy listed as the fourth ingredient or further down the list	
Egg - *Do not serve the items checked below:*	**Serve these items instead:**
Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold Eggs used in breading or coating of products Baked products with eggs such as breads or desserts	
Seafood – *Do not serve the items checked below:*	**Serve these items instead:**
Fish (Cod, tuna, tilapia, haddock, salmon, etc.) Shrimp Other:____________________	
Peanuts – *Do not serve the items checked below:*	**Serve these items instead:**
Peanuts, individually or as an ingredient Foods containing peanut oil Foods items identified as manufactured in a plant that also handles peanuts	
Tree nuts – *Do not serve the items checked below:*	**Serve these items instead:**
All nuts Food items identified as manufactured in a plant that also handles nuts Other: ____________________	
Grains – *Do not serve the items checked below:*	**Serve these items instead:**
Foods containing wheat Foods containing gluten Oats Other: ____________________	