**Food Allergy Individual Health Care Plan**

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ 504 Plan \_\_\_\_\_\_\_\_\_ IEP \_\_\_\_\_\_\_\_\_\_ Medical Alert

|  |  |  |  |
| --- | --- | --- | --- |
| STUDENT INFORMATION | | | |
| Student: | School Year: | | School: |
| Date of Birth: | Age: | | Grade: |
| Parent/Guardian: | | | |
| Lives with: \_\_\_\_ Both Parents \_\_\_\_Mother \_\_\_\_ Father \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Parent/Guardian Phone: | | Parent/Guardian Phone: | |
| Parent/Guardian Cell: | | Parent/Guardian Cell: | |
| Other Contact: | |  | |
| Physician: | | Phone: | |
| Physician: | | Phone: | |
| School Nurse: | | Phone: | |

**Prevention**

*Problem*: Potential for anaphylaxis and or less serious allergic reactions secondary to exposure to food allergen:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*Interventions:*

Avoid exposure to food allergen:

School Nurse/ Parent will inform teachers, food service employees, emergency response team members in school building about student’s food allergy at the beginning of every school year/ semester (if applicable- MS/HS).

 Teacher/Nurse will call parent to question whether a particular food product is safe if unsure.

 If food provided by classmate has unknown content, allergic student will be instructed not to ingest it.

 At snack and lunch time, supervising staff will monitor student activity to prevent sharing of foods or exposure in any way (through topical exposure) between allergic student and classmates.

 Student will be instructed to tell staff immediately if exposed either through ingestion or topically to food allergen.

|  |
| --- |
| GOALS |
|  Student will avoid exposure to allergen   Student will not have any allergic reactions  Date Notified: \_\_\_\_\_\_\_\_\_\_ Classroom Teachers \_\_\_\_\_\_\_\_Building Food Service workers \_\_\_\_\_\_\_\_ Building First Responders By Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| ACTION PLAN |
| **ALLERGY TO**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthmatic Yes☐ No☐ \*Higher risk for severe reaction  **STEP 1: TREATMENT**  **Symptoms:**  If a food allergen has been ingested, but *no symptoms*: ☐ Epinephrine ☐ Antihistamine ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_   Mouth: Itching, tingling, or swelling of lips, tongue, mouth ☐ Epinephrine ☐ Antihistamine   Skin: Hives, itchy rash, swelling of the face or extremities ☐ Epinephrine ☐ Antihistamine   Gut: Nausea, abdominal cramps, vomiting, diarrhea ☐ Epinephrine ☐ Antihistamine   Throat: Tightening of throat, hoarseness, hacking cough ☐ 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  **DOSAGE Epinephrine:** inject intramuscularly (circle one) EpiPen® / EpiPen® Jr. / TwinjectTM 0.3 mg / TwinjectTM 0.15 mg  **Antihistamine:** give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication/dose/route  **Other:** give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication/dose/route  **IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**    **\*\*Nebulizer medication and tubing must be provided by parent/guardian\*\*** |
| TRAINED STAFF MEMBERS |
|  |

**\*\*\* A completed Medication Authorization Form must be signed by both parent and physician and on file before any**

**medication can be given or carried at school**

As a parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I give my permission to the school nurse and other trained designated staff to perform and carry out the health tasks as outlined in this Individual Health Plan (IHP). I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student’s health status or care. Parent/Guardian are responsible for the maintaining of necessary supplies, medications and equipment.

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_