River Edge Food Allergy Health Care Plan

Student's Name:________________________ D.O.B._________ Teacher:_______________

ALLERGY TO: ____

SYMPTOMS

- Mouth Itching, tingling or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat Tightening of throat, hoarseness, hacking cough
- Lung Shortness of breath, repetitive coughing, wheezing
- Heart Thready pulse, low blood pressure, fainting, pale, blueness

The severity of symptoms can quickly change. Above symptoms can potentially progress to a life-threatening situation.

STEP 1: TREATMENT

(To be filled out by Physician)

Medicine

Antihistamine: give ____
Medication/dose/route

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Auvi-Q Auvi-Q Jr.

Doctor's Signature ________________________________ Date _______________

STEP 2: EMERGENCY CALLS

(To be filled out by Parent)

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____________________ at _______________________
3. Emergency contacts: Name / Phone #

a.____________________________ _________________

b.____________________________ _________________

c.____________________________ _________________

Parent/Guardian Signature ________________________________ Date __________________

Principal's Signature ______________________________________ Date __________________

Trained Staff Members:

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