School District of Iola-Scandinavia-Confidential

Health Services: Emergency Plan-Food Allergy

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

Food Allergy (Please be specific): _____

Please describe child's reaction:

_____

Signs of an allergic reaction include: (Please circle all that apply)

Systems:	**Symptoms:**
Mouth	Itching & swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, itching rash, and/or swelling about the face or extremities
Abdomen	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	"Thready" pulse, low blood pressure, fainting, pale, blue lips/nail beds
Other	_____

Severity of symptoms can change quickly. All above symptoms can potentially progress to a life threatening situation*

Please tell us what you want us to do in case of an allergic reaction at school (Please circle all that apply)

___Observe and record side effects

___Notify Parent immediately

___Allow to rest for ____ minutes

___Call 911 (If an Epi-pen is used, 911 will be called per school policy)

___Administer medication**

Medication Dosage When do you give medication?

1._____

2._____

If your child requires medication, you must have a MEDICATION AUTHORIZATION FORM must be signed and accompany with both parent and doctors signature Please fill out back of form….

Any additional information you would like us to know: _____

_____

_____

Doctor(s) Treating Food Allergy: _____ Phone: _____

Doctors Address: _____

Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email address:	Email address:	Email address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: _____Date: _____

School Nurse Signature: _____ Date: _____