

Report on a Student with Allergies + Allergy Action Plan

(STUDENT LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

1. DIAGNOSED ALLERGY: FOOD ALLERGY NON-FOOD ALLERGY UNKNOWN ALLERGY
 DATE STUDENT WAS DIAGNOSED WITH ALLERGY: _____
 PLEASE LIST ALL STUDENT'S SPECIFIC ALLERGENS: _____

2. DOES STUDENT REQUIRE EMERGENCY EPINEPHRINE (i.e. EpiPen, Auvi-Q)?: YES NO (IF YES, PLEASE COMPLETE PERMISSION FOR SELF-CARRY QUESTION (2A.) AND ANAPHYLAXIS EMERGENCY CARE PLAN)
 2A. PERMISSION FOR SELF-CARRY (+ permission for self-administration) OF EMERGENCY EPINEPHRINE BY ABOVE NAMED STUDENT?: YES NO

***Note to Parents:** Per CPS protocol, in the event emergency epinephrine is administered, 911 MUST be notified

DAILY or PRN MEDICATION PLAN (Please include any oral antihistamines that can be given)

***Note to Parents:** ALL medications, including over-the-counter (OTC) medications, must be provided to the school in their original packaging and labeled with the student's name. The medication's dosage must also match what is prescribed below.

MEDICATION NAME	DOSAGE	SCHEDULED TIME

Provider's Name (PRINT) _____ Provider's Signature _____
 Hospital/Clinic Affiliation _____ Address _____
 Telephone # _____ Fax # _____ Date _____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

PRIMARY EMERGENCY CONTACT

Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACT

Name/Relationship: _____ Phone: _____



FARE

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

For ANY of the following SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION

of symptoms from different body areas

1. INJECT EPINEPHRINE IMMEDIATELY.
 2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE BODY SYSTEM, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE BODY SYSTEM (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE

DATE

Form provided courtesy of Food Allergy Research & Education (FARE - FoodAllergy.org) - January 2023

