



BUCKEYE LOCAL SCHOOL DISTRICT

BUCKEYE LOCAL BOARD OF EDUCATION

3044 Columbia Road
Medina, Ohio 44256
Phone: 330-722-8257

Food Allergy Action Plan

Student's Name:	School/Grade:
Date of Birth:	Contact Teacher:
Parent/Guardian Name:	Phone (Family):
Address:	
Emergency Number:	
Physician:	RN:
Emergency Medication Location:	

Allergy to: _____

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

Extremely reactive to the following foods:

_____ Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

_____ Give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

The student is capable of possessing and using the auto injector appropriately per MD orders.

The student has been trained on the proper use of auto injector.

* If either of the above boxes are **NOT** checked student may **NOT** carry auto injector.

One epinephrine auto-injector is **REQUIRED to be stored in the school clinic.

1. Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

Treatment:

LUNG: Short of breath, wheeze, repetitive cough

1. INJECT EPINEPHRINE IMMEDIATELY.

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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, diarrhea, crampy pain

2. Call 911.
3. Begin monitoring.
4. Give additional medications (if ordered):
 - a. Antihistamine
 - b. Inhaler (bronchodilator) if asthma

2. MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
EPINEPHRINE.
GUT: Mild nausea/discomfort

Treatment:

1. GIVE ANTIHISTAMINE.
2. If symptoms progress (see above), USE
3. Begin monitoring.

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____

Registered Nurse _____ Date _____

MEDICAL REVIEW

I have reviewed the attached Action Plan for _____, AND:

_____ I approve the Action Plan as written.

_____ I approve the Action Plan with the attached amendments.

_____ I do not approve of the Action Plan as written, and substitute orders are attached.

Physician _____ Date _____

Other Recommendations

Copies to: Board Office Bus Garage Teacher Other