1745 West Grand
Haysville, Kansas 67060
Phone: 316-554-2200
Fax #: 316-554-2230

USD 261
HAYSVILLE

Mary Parker, R.N.
District School Nurse

FOOD ALLERGY ACTION PLAN

Dear Parents or Guardian:

This plan should be completed by the student's physician and parents/guardian. Please have the physician to give guidelines on type of food allergy and treatment protocol, so that the school staff will be clear on what is to be done.

Please have the physician complete the attached form "Permission to Administer Medication" if medication is to be given at school. Please send all medication in original labeled container from the pharmacy.

Each school year this plan must be completed by the student's physician and parents/guardian. If you have any questions or concerns, please call the Nurse or Health Aide in your child's school.

Thank you,
Mary Parker, R.N.
District School Nurse for Haysville Schools

Food Allergy Action Plan

Name:_____ D.O.B:_____ Teacher:_____

ALLERGY TO:_____

Asthmatic Yes:_____ No:_____ (Higher risk for severe reaction)

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but no symptoms:	___Epinephrine	___Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	___Epinephrine	___Antihistamine
• Skin: Hives, itch 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: Pale, blue, faint, weak pulse, dizzy, confused, low blood pressure	___Epinephrine	___Antihistamine
• Other_____	___Epinephrine	___Antihistamine
• If reaction is progressing (several of the above affected), give:	___Epinephrine	___Antihistamine

Medication/Dosage:

Epinephrine (brand and dose):_____

Antihistamine (brand and dose):_____

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

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS AND MONITORING

1. Inject epinephrine and note time administered then immediately call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents, guardian or emergency contacts.
3. Treat student even if parents or guardian cannot be reached.

Parent/Guardian_____ Phone: _____
Emergency Contact:
Name/Relationship:_____ Phone:_____

Parent/Guardian Signature_____ Date_____

Physician Signature_____ Date_____

Permission to Administer Medication
Haysville Public Schools
Health Services Department

Board Policy:

PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

Medications:

A. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
   a. Pupil's name
   b. Name of medication
   c. Dosage and directions for administration
   d. Date
   e. Prescribing physician's name

B. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.

_____ _____
Name of Student to Receive Medication Date of Birth

_____ _____
Print Name of Physician Phone

Name of Medication and Dosage to be given_____

For the Diagnosis of_____

Directions for administration and any other pertinent information:

_____

_____

Requested starting date of treatment_____ Expected duration of treatment_____

Request to administer the medication during regular school hours.

_____ _____
Signature of Parent/Guardian Physician's Signature

_____ _____ _____ _____
Phone Date Phone Date

_____ _____
Address Address