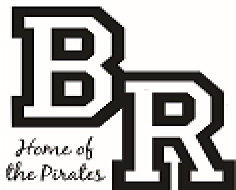

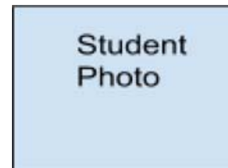

Black River Local Schools
257 A County Road 40
Sullivan, OH 44880-9731
www.blackriverschools.org

Elementary – Phone: 419-736-2161 Fax: 419-736-2165
High School – Phone: 419-736-3303 Fax: 419-736-3302
Middle School – Phone: 419-736-3304 Fax: 419-736-3309
Board Office – Phone: 419-736-3300 Fax: 419-736-3308

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:

<u>One or more</u> <u>of the following:</u>
LUNG: Short of breath, wheeze, repetitive cough
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

<u>Treatment</u>:
1. **INJECT EPINEPHRINE IMMEDIATELY.**
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
GUT: Mild nausea/discomfort

<u>Treatment</u>:
1. GIVE ANTIHISTAMINE.
2. If symptoms progress (see above), USE EPINEPHRINE.
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 <u>not</u> approve of the Action Plan as written, and substitute orders are attached.

Physician ____ Date ________________________________

Other Recommendations

Copies to:
☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other