WESTWOOD PUBLIC SCHOOLS

Honoring Tradition, Inspiring Excellence, Shaping the Future

Food Allergy Individual Health Plan

(Intended for use during the school day only)

School year___________ GRADE:________

Place Student's Picture Here

Name:_______________________________________ D.O.B.: _________________

Allergy to:____

Weight:_________lbs. Asthma: Yes ☐ (higher risk for a severe reaction) No ☐

Extremely reactive to the following foods:____

THEREFORE:

_______ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

_______ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

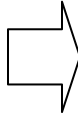
Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

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



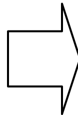
1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911**
3. Begin Monitoring (see box below)
4. Give additional medications:*

-Antihistamine -Inhaler (Bronchodilator) if asthma

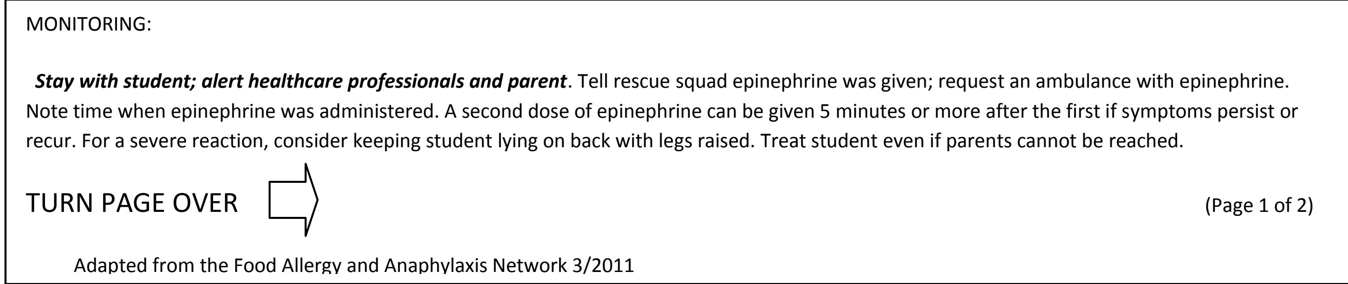
*Antihistamines and inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis) **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)



MONITORING:

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

TURN PAGE OVER

Adapted from the Food Allergy and Anaphylaxis Network 3/2011

MEDICATION ORDERS:

EPINEPHRINE (0.3mg) IM PRN _____ **EPINEPHRINE JR** (0.15mg) IM PRN _____

REPEAT DOSE OF EPINEPHRINE, IF NEEDED_____ IF yes, when______________________________
Side effects to watch for____
****STUDENTS IN MIDDLE AND HIGH SCHOOL**** carry their own EPINEPHRINE for field trips and after school activities.
*STUDENT MAY SELF ADMINISTER EPINEPHRINE________

ANTIHISTAMINE (NAME, DOSE & FREQUENCY)____
Side Effects to watch for:____
INHALER (NAME, DOSE & FREQUENCY)____
Side Effects to watch for:____
Other medications being taken by student:____

****Licensed Health Care Provider's Signature**_**______________________________________
Licensed Heath Care Provider's Printed Name____________________________________
Date Completed:____
PHONE NUMBER :____

PARENTAL CONSENT:

1. I have read and reviewed the Health Care Plan formulated by my child's physician. I give permission for the school nurse or her trained designee to follow the Plan. I understand that the emergency plan will be sent and followed on all field trips. ****Students at the Middle School and High School carry their own EPINEPHRINE for field trips and after school activities **.**

This form is intended for the scheduled school day only; it is not valid for Extended Day.

2. I give permission for this information to be shared with the school staff as needed for my child's safety.

3. I will contact the Food Services Department (781-326-7500 ext. 4350) to discuss any dietary needs my child may have.

4. The school nurse will consult verbally and/or in writing with the student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition.

Parent/guardian signature____Date:____________
School Nurse signature____Date:____________

CONTACTS:

PARENT/GUARDIAN NAME: ____

HOME PHONE:____

CELL PHONE:____

EMAIL ADDRESS:____

**This plan is in effect for the current school year only **