

**WILLIAMSBURG SCHOOLS FOOD ALLERGY ACTION PLAN  
MEDICATION ORDER FORM & PARENT CONSENT**

Student \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

**ALLERGIC TO:** \_\_\_\_\_ **BY:** Ingestion Contact Inhaled

**ALLERGY HISTORY**

(To Be Completed By Health Care Provider)

Does the child have a documented anaphylactic reaction? Yes No If yes, when \_\_\_\_\_

What were the child's past allergy reaction symptoms? \_\_\_\_\_

Does the child have asthma? Yes No (higher risk for severe reaction in an asthmatic child)

**PHYSICIAN'S ORDER AND TREATMENT PLAN**

(Circle medication and dosage)

**If the child ingests the food allergen please be prepared to administer the following medications.**

**Epinephrine** (give intramuscularly in thigh) 0.15 mg 0.3 mg Other \_\_\_\_\_  
Repeat epinephrine if symptoms persist and ambulance has not arrived? Yes No

**Antihistamine** (give orally, if student can swallow) 12.5 mg 25 mg 50 mg

**Albuterol Inhaler** \_\_\_\_\_

- If this child ingests food allergen, give epinephrine immediately. Do not wait for symptoms.**
- If this child ingests food allergen, watch for symptoms that may require epinephrine. See Treatment Plan below.**

**TREATMENT PLAN**

**If symptoms of:**

<b>MOUTH</b>	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
<b>SKIN</b>	Hives, itching, rash, swelling of the face or extremities	Epinephrine	Antihistamine
<b>GUT</b>	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
<b>THROAT</b>	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
<b>LUNG</b>	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
<b>HEART</b>	Weak pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
<b>OTHER</b>	_____	Epinephrine	Antihistamine
<b>If reaction progresses (several areas above affected) repeat administration:</b>		Epinephrine	Antihistamine

I authorize that this child is age appropriate to carry and self-administer his/her own EpiPen if needed. Yes No

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

**TRANSPORT/EMERGENCY/PARENT CONSENT**

**If epinephrine administered call 911 IMMEDIATELY**

Transport my child via ambulance to (hospital preference) \_\_\_\_\_

*If a parent/guardian cannot be reached the child will be transported to the preferred hospital listed.*

- I give consent for the school nurse/delegated and trained personnel to implement the plan above and administer medications as prescribed by my child's physician.
- I give consent for school & bus personnel to be made aware of my child's allergy and the above treatment plan in order to quickly recognize allergic symptoms, retrieve emergency medication and get prompt care.
- I agree with above treatment plan as prescribed by my child's physician and will update the school nurse if there are any changes in my child's treatment plan or allergy status.

Parent/Signature \_\_\_\_\_

Date \_\_\_\_\_