

Food Allergy Awareness Form

Senior name: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/Work: _____

Health Care Provider treating food allergy: _____ Phone: _____

Do ***you think*** your senior's food allergy may be ***life threatening***? NO YES

Did your senior's ***Health Care Provider*** tell you the food allergy may be (come) ***life-threatening***? NO YES

History and Current Status:

Check the foods that have caused an allergic reaction:

- | | |
|---|---|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Milk or other dairy products |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products |
| <input type="checkbox"/> Peanut or nut oils | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) | <input type="checkbox"/> Fish / shellfish |

Other allergies (Please list any other allergens.) _____

How many times has your senior had a reaction? Never Once More than once, please explain:

Does your senior understand how to avoid foods that cause allergic reactions? NO YES

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

Have you used the treatment? NO YES

Does your senior know how to use the treatment? NO YES

Please describe any side effects or problems your senior had in using the suggested treatment:

Do you intend for your senior to eat parent party committee provided meals? NO YES

Will your senior be bringing medication / treatment to the party? NO YES

What do you want the parent planning committee to do at the party to help your senior avoid problem foods?

I give my consent to share with the chaperones, that my senior has a life-threatening food allergy.

NO YES

Parent / Guardian Signature: _____ Date: _____

Life-Threatening Food Allergy Emergency Care Plan (ECP)

Student Information			
Student Name:		Life-Threatening ALLERGY to:	
Emergency Contact 1 (Full Name & Phone #):		Emergency Contact 2 (Full Name & Phone #):	
Student should avoid contact with this/ these allergen(s):			
Other allergies:			
School:	Birthdate:	Grade:	Night-of-Event Bus #: <i>Onsite help to enter day of event</i>
Routine medications (at home/school):		Asthmatic? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last reaction:
Is it medically necessary for student to carry their own EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO		High Risk for life-threatening reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Please list the specific symptoms the student has experienced in the past.			
<input type="checkbox"/> MOUTH Itching, tingling, and/or swelling of the lips, tongue, or mouth <input type="checkbox"/> SKIN Hives, itchy rash, and/or swelling about the face or extremities <input type="checkbox"/> THROAT Sense of tightness in the throat, hoarsened and hacking cough <input type="checkbox"/> GUT Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea <input type="checkbox"/> LUNG Shortness of breath, repetitive coughing, and/or wheezing <input type="checkbox"/> HEART "Thready" pulse, "passing out", fainting, blueness, and pale <input type="checkbox"/> GENERAL Panic, sudden fatigue, chills, fear of impending doom <input type="checkbox"/> OTHER _____			
IF YOU SUSPECT A LIFE-THREATENING ALLERGIC REACTION TO FOOD, IMMEDIATELY ADMINISTER EPINEPHRINE AND CALL 911.			
Medication Doses			
EPIPEN (.03) <input type="checkbox"/>	EPIPEN JR. (0.15) <input type="checkbox"/>	ANTI-HISTAMINE:	
Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ CC / MG (circle one)	
Repeat dose of EPIPEN: <input type="checkbox"/> YES <input type="checkbox"/> NO		Side Effects:	
If YES, when:			
Give (list medication) _____ _____ Teaspoons _____ Tablets by mouth		Side Effects:	
Signature of Licensed Health Professional: _____			Date: _____
Printed Name of Licensed Health Professional: _____			
Action Plan			
<ol style="list-style-type: none"> 1. Administer Epinephrine AND CALL 911 (DO NOT HESITATE to administer Epinephrine). 2. 911 MUST BE CALLED IF EPINEPHRINE IS ADMINISTERED. 3. Advise 911 that the student is having a life-threatening allergic reaction AND Epinephrine is being administered. REQUEST ADVANCED LIFE SUPPORT. 4. Note the time of Epinephrine administration: _____ AM / PM 5. Place EpiPen in the container provided AND send with emergency responders along with ECP. 6. Call Parents or other emergency contacts. 			