# FOOD ALLERGY FORM

If child is allergic please place a picture here

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**STUDENT NAME:** ______________________________ **D.O.B:** __________

**ALLERGY TO:** ______________________________________________

If child is not allergic to anything fill out "NO KNOWN ALLERGY" skip step 1, and 2 and **sign at the** 'PARENT/GUARDIAN'S field at the bottom.

If child is allergic, fill out the entire form. **PARENT and DOCTOR** need to sign at the bottom. **DOCTOR** needs to have his stamp or License number.

**Asthmatic** Yes* ☐ No ☐ *Higher risk for severe reaction

## STEP 1: TREATMENT

| Symptoms: | Give checked Medication **: **(To be determined by physician with Doctors instructions authorizing treatment) | | | |
|---|---|---|---|---|
| ■ If food allergen has been ingested, but no symptom: | | Epinephrine | | Antihistamine |
| ■ Mouth Itching, tingling, or swelling of lips, tongue, mouth | | Epinephrine | | Antihistamine |
| ■ Skin Hives, itchy 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 ♣ Weak or thready pulse, low blood pressure, fainting, pale, blueness | | Epinephrine | | Antihistamine |
| ■ Other ♣ ______________________ | | Epinephrine | | Antihistamine |
| ■ If reaction is progressing (several of the above areas affected), Give: | | Epinephrine | | Antihistamine |
| ♣Potentially life threatening. The severity of symptoms can quickly change. | | | | |

**Parents need to provide the Epinephrine and Antihistamine**

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen®, EpiPen® Jr., Twinject® 0.15 mg
**Antihistamine:** give______________________________________________
Medication/ dose/ route

**Other:** ______________________________________________
Medication/ dose/ route

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

## STEP 2: EMERGENCY CALLS

1. **Call 911,** state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________ Phone Number(s)______________________
3. Emergency contacts: Name / Relationship Phone Number(s)

a. ______________________ 1)______________ 2) ______________

b. ______________________ 1) ______________ 2) ______________

**EVEN IF PARENT/ GURADIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

**PARENT/GUARDIAN'S** Signature: ______________________ Date: __________

**DOCTOR'S** Signature: ______________________ Date: __________
With License Number and/or Stamp