Southern Lehigh School District
5775 Main Street
Center Valley, PA 18034

Food Allergy Assessment Form

Student's Name: _____ *Date of Birth:* _____

Grade: _____ *Homeroom:* _____

Dear Parent/Guardian:

You brought to our attention that your child is allergic to certain foods. In order to provide the best care for your child, please complete this form and return it to the school nurse as soon as possible.

If your child needs any medication such as Benadryl or an Epi-Pen, you must provide it along with a completed Medication in School Form (including your physician's signature and procedures to follow).

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

Nursing Department

1. *Foods that produce an allergic response (please be as specific as possible)*

_____
_____
_____
_____

2. *Must the food be eaten or has a reaction occurred in response to touching or smelling?*

_____

3. *What reactions or symptoms have occurred in the past (please check all that apply)*

_____ *Hives*
_____ *Wheezing*
_____ *Coughing*
_____ *Breathing Difficulty*
_____ *Swelling of Lips or Tongue*
_____ *Blue Lips or Skin*
_____ *Generalized Itching*
_____ *Hives*
_____ *Nausea*
_____ *Vomiting*

Other (please describe) _____
_____

4. *Procedure to be followed in the event of an allergic response at school*

_____
_____
_____

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Food Allergy Research & Education

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE