

FOOD ALLERGY TREATMENT PLAN AND
PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ TELEPHONE: _____

PHYSICIAN'S NAME: _____ PATIENT'S PCP: _____

ASTHMA YES NO

SPECIFIC FOOD ALLERGY: _____

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:

- _____ Observe patient for symptoms of anaphylaxis** for 2 hours
- _____ Administer adrenaline before symptoms occur, IM EpiPen Jr. Adult
- _____ Administer adrenaline if symptoms occur, IM EpiPen Jr. Adult
- _____ Administer Benadryl _____ tsp. or Atarax _____ tsp. Swish & Swallow
- _____ Administer _____
- _____ Call 911, transport to ER if symptoms occur for evaluation, treatment and observation for 4 hours

IF REACTION OCCURS,
PLEASE NOTIFY THIS OFFICE! Physician's Signature _____ Today's Date _____

1. Is this a controlled drug? Yes No Time of administration: _____
2. Medication shall be administered from _____ to _____ (dates)
3. Relevant side effects, if any, to be observed: _____
4. Other Suggestions: Please allow child to self-administer medication if able to _____

Signature: _____ M.D. Date: _____

**SYMPTOMS OF ANAPHYLAXIS

- Chest tightness, cough, shortness of breath, wheezing
- Tightness in throat, difficulty swallowing, hoarseness
- Swelling of lips, tongue, throat
- Itching mouth, itchy skin
- Hives or swelling
- Stomach cramps, vomiting, or diarrhea
- Dizziness or faintness

I have received, reviewed, and understand the above information.

Patient/parent/guardian signature Date