Attach student picture here

**Shelby County Public Schools**
**Food Allergy Action Plan**

**Student's Name: ________________________________________ Date of Birth: __/__/____**

**Allergy to : ______________________________________________________________________________**

**Is a Nut free table needed:** □**Yes** □**No** **Asthmatic:** □ **Yes** □ **No** (Yes is a higher risk for severe reaction

**Symptoms:** **Give Checked Medication:** (to be determined by physician)

| Symptoms | Give Checked Medication |
|---|---|
| If allergen has been ingested but **NO** symptoms | □ 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***: Thready pulse, low blood pressure, fainting, blueness | □ Epinephrine □Antihistamine |
| **Other:** ______________________________________________ | □ Epinephrine □Antihistamine |

***Life threatening activate 911.**

**Emergency Medications:**

Epinephrine : □Epi Pen Jr. □Epi Pen □Auvi Q 0 .15mg □Auvi Q 0.3 mg □Twinject 0.15mg □ Twinject 0.3mg

Antihistamine (medication name, dosage, route)______________________________________________________________

Other emergency medication: (Medication name, dosage , route)__________________________________________________

**Physician's Signature: __________________________________________Date: ____________________**
**Physician's Name (printed): _____________________________________Phone Number: ____________________**

Pursuant to KRS 158.832 to KRS 158.836 Shelby County Public Schools permit a student to possess and self administer Asthma or Anaphylaxis medication at school and at school related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self –administering of the above named emergency medication:
□No □Supervision required □Supervision NOT required

This student may carry the Epinephrine auto-injector: □Yes □No
Physician's Signature: __________________________________________Date: ____________________
Physician's Name (printed): _____________________________________Phone Number: ____________________

I give my permission for my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of Shelby County Public Schools and school personnel as a result of the administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable physician orders to be followed.

**Parent/Guardian Signature: ______________________________ Date: ______________________**
**Home Phone: _________________ Work Phone: ____________________ Cell Phone: ________________________**
In the event of an allergic reaction and the parent cannot be reached, please contact:

Name: ___________________________ Home Phone: ______________________ Cell Phone: _____________________

Name: ___________________________ Home Phone: ______________________ Cell Phone: _____________________

Name: ___________________________ Home Phone: ______________________ Cell Phone: _____________________