Valparaiso Community Schools **ALLERGY/ DIET SENSITIVITY ACTION PLAN**

NAME: _____ DOB: _____
School / Grade: _____ ID# _____

Non-Disabling Medical Condition/Allergy : _____
OR
Disability: _____ **Major Life Activity Affected**: _____

Medication Authorization : Benadryl given as first line of care followed by Epipen (if needed) unless indicated below.

- ☐ No medication needed
- ☐ Benadryl (dosage) _____
- ☐ Epinepen ____ Jr. (0.15mg) _____ Epi-pen (0.3mg) ____ Quavar ___ Other _____
- ☐ Other : _____
- ☐ Student may carry and self-administer Epi-pen, (if child carry agreement on file in the clinic)

Diet Prescription : (check all that apply)

☐ Increased calories ☐ Decreased calorie ☐ Diabetic ☐ Food allergy _____
☐ Other _____

Texture modification: ☐ Chopped ☐ Ground ☐ Pureed

Food to Omit: _____ **Substitution :** _____
Food to Omit: _____ **Substitution:** _____

Physician Signature: _____ Date:_____
Phone: _____ Fax: _____

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Date of Last Reaction: _____ Treatment that was needed: _____

PAST SYMPTOMS OF AN ALLERGIC REACTION: (Please Circle)

Systems:	Symptoms:
*MOUTH	Itching & swelling of the lips, tongue, or mouth
*THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
*SKIN	Hives, itchy rash, and/or swelling about the face or extremities
*STOMACH	Nausea, abdominal cramps, vomiting, and/or diarrhea
*LUNG	Shortness of breath, repetitive coughing, and/or wheezing
*HEART	"Thready" pulse, "passing-out"
*OTHER (list)	_____

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life- threatening situation. 911 will be called for ALL Epi-pen administrations. Parent will be responsible for supplying all medication to the school in an original labeled container.

EMERGENCY CONTACT

(1)_____Phone:_____ Relationship:_____
(2)_____Phone:_____ Relationship:_____

I understand that should I or designated persons not be available, School personnel will contact Emergency Medical Services at my expense. This action plan may be shared with school, coaching, or supervisor personnel. This serves as permission for two way communication with Physician.

Parent Signature:_____ Date: _____

☐ Nurse ☐ Kitchen ☐ FNS office

Allergy orders 3/15