MCS Health Services

Food Allergy Action Plan

Emergency Medication Release Form

Place Student's Picture Here

Student's Name: **Grade:** **Date of Birth:** / /

Allergic to:

Weight: lbs **Asthma:** ☐ Yes (higher risk for a severe reaction ☐ No

Parent/Guardian Name: **Emergency Phone:**

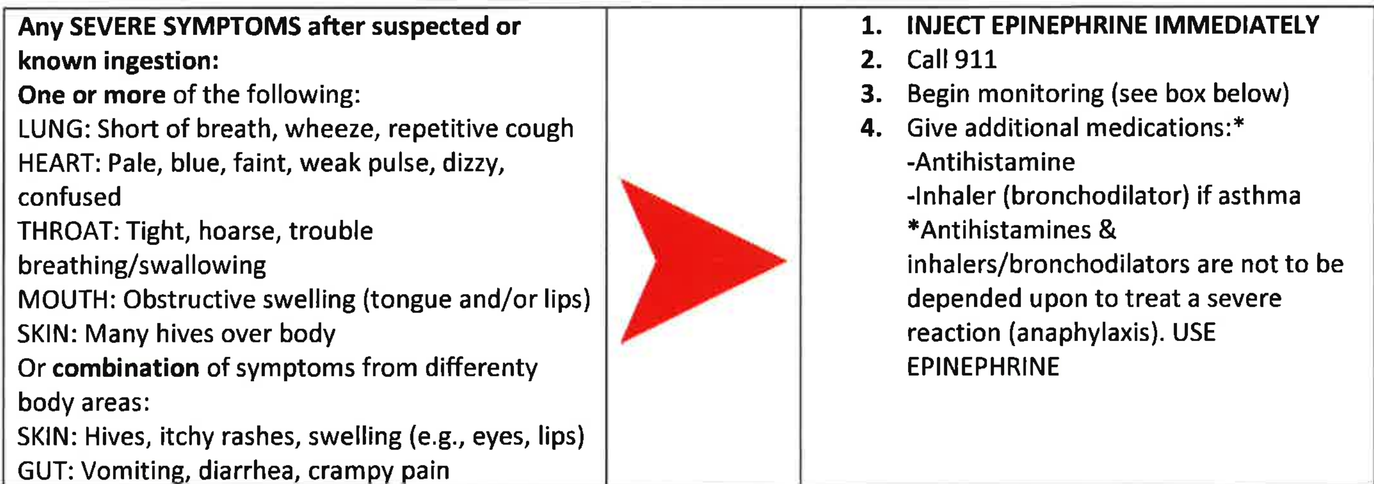
Parent/Guardian2 Name: **Emergency Phone2:**

Extremely reactive to the following foods:

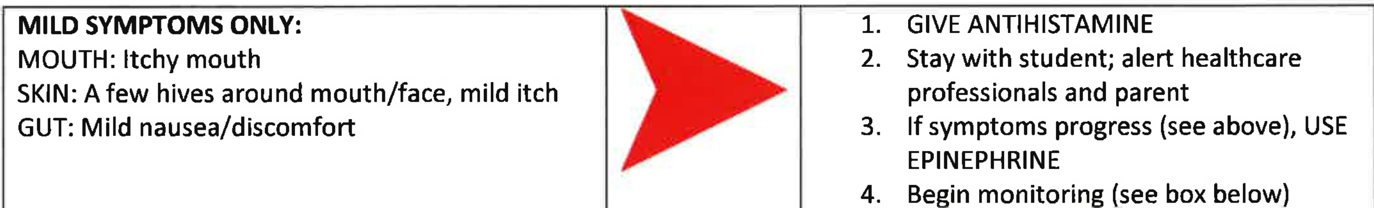
THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted



Symptoms		Action
Any SEVERE SYMPTOMS after suspected or known ingestion: **One or more** of the following: LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from differenty body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, diarrhea, crampy pain		**1. INJECT EPINEPHRINE IMMEDIATELY** **2.** Call 911 **3.** Begin monitoring (see box below) **4.** Give additional medications:* -Antihistamine -Inhaler (bronchodilator) if asthma *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE



Symptoms		Action
MILD SYMPTOMS ONLY: MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort		1. GIVE ANTIHISTAMINE 2. Stay with student; alert healthcare professionals and parent 3. If symptoms progress (see above), USE EPINEPHRINE 4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose):

Antihistamine (brand and dose):

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

I hereby RELEASE, DISCHARGE, and HOLD HARMLESS Maranatha Christian Schools (MCS), its School Board, staff, and agents from all liability, including injury, death, adverse reactions, or other damages which may arise from the administration or assisting with administration of medication according to the authorization and instructions of the prescribing physician. I agree to provide the medications indicated above in, sealed, original containers, and/or prescription containers which are labeled with the name of my child, the prescribing physician, the medication, clear and precise directions, and dosage.

Parent/Guardian Signature Date Physician/ Healthcare Provider Signature Date