MOSINEE SCHOOL DISTRICT
INDIVIDUALIZED SEVERE FOOD ALLERGY ACTION PLAN

Student Name: _____ Grade: _____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work/Day Phone: _____

My child also has asthma (higher risk for severe reaction): ☐ Yes ☐ No

FOOD ALLERGIES: (Check / list all that apply)

☐ Peanuts

☐ Tree Nuts Specify: _____

☐ Fish/Seafood Specify: _____

☐ Fruit Specify: _____

☐ Dairy Products Specify: _____

☐ Other Specify: _____

Check all that apply:

☐ My child has a severe allergic reaction when he/she eats the above listed food/food products.

☐ My child has an allergic reaction when he/she touches the residual oils of the above listed food/ food product.

☐ My child has an allergic reaction when he/she breathes in the above listed food/ food product.

☐ My child needs to sit at a designated "safe" table in the cafeteria (with neighboring students who do not have the allergen in their lunch).

EPI PEN/MEDICATION ADMINISTRATION:

If the above listed food allergen is ingested (eaten), but my child has no symptoms of an allergic reaction, Epi Pen should be administered. ☐ Yes ☐ No _____ Physician Initials

If my child has been exposed to the food allergen at school, Epi Pen will be administered when symptoms appear.

☐ Yes ☐ No _____ Physician Initials

SYMPTOMS (to be completed by physician authorizing treatment):	**Give Checked Medication:**	
Mouth: Itching, tingling or swelling of lips, tongue, mouth	☐ Epi Pen	☐ Antihistamine
Skin: Hives, itch/rash, swelling of the face or extremities	☐ Epi Pen	☐ Antihistamine
Throat: Tightening of throat, hoarseness, hacking cough	☐ Epi Pen	☐ Antihistamine
Lungs: Shortness of breath, repetitive coughing, wheezing	☐ Epi Pen	☐ Antihistamine
Heart: Thready pulse, low blood pressure, fainting, paleness	☐ Epi Pen	☐ Antihistamine
Other (list): _____	☐ Epi Pen	☐ Antihistamine

If antihistamine is checked above, indicate name and amount to be given: _____

ADDITIONAL INFORMATION/RESPONSIBILITIES:

1. My child will take hot lunch/breakfast. ☐ Yes ☐ No ☐ Sometimes
   It is the responsibility of the parent to review the breakfast/lunch menu with his/her child.
2. Students are NOT to share snacks or eating utensils at school.
3. For elementary school students, parents are asked to provide a box of safe snacks for their child to eat as a substitute for special occasion parties/birthday treats. I will provide a box with safe snacks for my child. ☐ Yes ☐ No _____ Parent Initials
4. I agree that my child's allergy information will be shared with appropriate staff. My child's picture will be displayed in a non-public location in the food service area.
5. I have completed the Parent/Practitioner Medication Authorization form. ☐ Yes ☐ No
6. Additional information/considerations: _____

_____

PERMISSION/SIGNATURE SECTION:

I verify that the above information is correct. I understand that the District Nurse will instruct staff on how and when to administer the Epi Pen to my child. I understand that 911 will be called if/when the Epi Pen is administered.

Parent/Guardian Signature: _____ Date: _____

Physician/Practitioner Signature: _____ Date: _____

Physician Name (Print): _____

MOSINEE SCHOOL DISTRICT
PARENT / PRACTITIONER MEDICATION AUTHORIZATION

(Practitioner includes physician, dentist, podiatrist, optometrist, physician assistant and advanced practice nurse practitioner per 2001 Wisconsin Act 83.)

ALL medications given at school must have written permission by the parent/guardian. ALL **prescription** medication given at school, including students who carry and self-administer inhaler and Epi Pens, must have written instructions signed by the practitioner AND the parent/guardian. No practitioner signature is required for over-the-counter (non-prescription) medication *providing* the dose is within the manufacturer's guidelines and does NOT contain aspirin.

Student Name: _____ Birthdate: _____ Grade: _____

Medical Diagnosis(es) _____

Medication(s)	Dosage & Route	Times Given at School	Specific Instructions

Medication order effective from: _____ until: _____

SELF-CARRY MEDICATION SECTION

Student can correctly use his/her medication? ☐ Yes ☐ No

Inhaler for breathing conditions: May carry self-administer? ☐ Yes ☐ No

Epi Pen for severe allergic reaction: May carry self-administer? ☐ Yes ☐ No

Insulin for diabetes: May carry self-administer: ☐ Yes ☐ No

Other medication: _____ May carry self-administer? ☐ Yes ☐ No

PRACTITIONER SIGNATURE SECTION

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Practitioner Signature: _____

Date: _____

Practitioner Name, Address, Phone: _____

_____

_____

PARENT/GUARDIAN SIGNATURE SECTION

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my son/daughter according to the instructions stated above and authorize them to contact the practitioner, if necessary.

Parent/Guardian Signature: _____

Date: _____

It is understood that:

1. All medications must be in an original container. Original pharmacy container must include the student's name, name of medication, dose, and time of administration on the label. Over-the-counter (OTC) medication must be in the original bottle/box/container and must include dosing instructions (quantity and frequency of administration with age). Meds sent in baggies, Tupperware, etc. will NOT be given.
2. Whenever possible, medication will be administered at home, before and/or after school hours.
3. Whenever there is any change in instructions for the above medication/s, a new form MUST be completed. A new form must also be completed for each and every school year.
4. Students who self-carry medications are responsible for taking these medications on all field trips.
5. Students will be sent by rescue squad to the emergency room after using an Epi Pen or Glucagon.