**CANUTILLO INDEPENDENT SCHOOL DISTRICT**

# Food Allergy Action Plan / Nutritional Medical Statement

**(To be renewed every school year)**

Student ID# _____

Child's Name: _____ DOB: _____ School _____

Telephone#: _____ Teacher/Grade _____

**ALLERGIC TO:**

**Asthmatic:** ❑ **Yes* ❑ No **High Risk for Severe Reaction*

**Diagnosis:** (Include description of student's medical or other special dietary needs that restrict the child's diet)

_____

_____

**List food(s) to be omitted from diet:**

_____

_____

**List food(s) that may be substituted with available CISD Food Service items.**

_____

_____

**Length of time diet will be required:** _____

***Any specialty food items requested and or required must be provided by Parent / Guardian.***

**Signs/Symptoms of An Allergic Reaction**

| | |
|---|---|
| **Mouth** | Itching & swelling of lips, tongue or mouth, drooling. |
| ***Throat** | Itching and/or a sense of tightness in throat, hoarseness, hacking cough, choking. |
| **Skin** | Hives, itchy rash, and/or swelling of face or extremities, flushed face |
| **Abdomen** | Nausea, abdominal cramps, vomiting and/or diarrhea |
| ***Lung** | Shortness of breath, repetitive coughing, and/or wheezing, stridor |
| ***Heart** | "Thready" pulse, "passing out" |

The severity of symptoms can quickly change. ***Above symptoms can potentially progress to a life threatening situation. DO NOT hesitate to call 911**

## HEALTH ACTION PLAN

| Actions for MINOR reaction | Actions for MAJOR reaction |
|---|---|
| | |

| Emergency Contacts | Trained Staff Members |
|---|---|
| 1. _____/_____<br>Name/relation Phone<br>2. _____/_____<br>Name/relation Phone<br>3. _____/_____<br>Name/relation Phone | 1. _____Rm. _____<br>2._____ Rm._____<br>3._____ Rm. _____ |

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Physician Signature/Printed and/or Stamped Date

_____ _____

School Nurse Signature / Date Cafeteria Manager Signature / Date

**EPIPEN® AND EPIPEN® JR. DIRECTIONS**

**1. Pull off gray safety cap**


**2. Place black tip on outer thigh (always apply to thigh)**

**3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.**

Parent authorizes copies of this document to:

❑ Parent ❑ Teacher ❑ P.E. ❑ Library ❑ Music ❑ Transportation
❑ Nurse ❑ Cafeteria

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**REV 05/13**