Spartanburg
DAY SCHOOL

FOOD ALLERGY TREATMENT PLAN
GRADES K – 12

PLEASE COMPLETE ONLY IF YOUR CHILD HAS A FOOD ALLERGY.

First Name: _____ Middle: _____ Last: _____

Goes by: _____

DOB: _____ Gender: _____ Grade Entering: ____

ALLERGY TO: _____

Please complete the following steps:

- Return your health forms during the summer months so the school nurse can identify those students and parents to contact.
- Please speak to the school nurse and your child's teacher about your child's allergy.
- Please complete the following chart and choose the treatment option as determined by your physician.

Symptom:	Treat with Epinephrine?	Treat with Antihistamine?
Food allergen ingested, but no symptoms?		
Mouth: itching, tingling or swelling of lips, tongue, mouth?		
Skin: hives, itchy rash, swelling of face or extremities?		
Gut: nausea, abdominal cramps, vomiting, diarrhea?		
Throat*: tightening of throat, hoarseness, hacking cough?		
Lung*: shortness of breath, repetitive coughing, wheezing?		
Heart*: weak or thread pulse, low blood pressure, fainting, pale, blueness?		
Other*?		
If reaction is progressing (several of the above areas affected)?		

* potentially life-threatening. The severity of symptoms can change quickly.

_____Signature of Legal Guardian _____Date