Food Allergy Action Plan

Student's Name: _____

D.O.B: _____ Teachers:_____

Allergy to:_____

Asthmatic Yes*_____ No_____ *Higher risk for severe reaction

Step 1: Treatment

Symptoms:		Give checked medication** (To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but no symptoms:	
▪ Mouth	Itching, tingling or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	□ Epinephrine □ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
▪ Throat↑	Tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine
▪ Lung↑	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine □ Antihistamine
▪ Heart↑	Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine
▪ Other↑	_____	□ Epinephrine □ Antihistamine
	If reaction is progressing (several of the above areas affected), give	□ Epinephrine □ Antihistamine

The severity of symptoms can quickly change.↑Potentially life threatening.

Dosage

Epinephrine: inject instramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg

Antihistamine: give _____

Other: give _____

Step 2: Emergency Calls

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts
   Name/Relationship

	Phone number (s)	
a. _____	1._____	2. _____
b. _____	1._____	2. _____
c._____	1._____	2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY:

Parent/Guardian Signature _____ Date: _____

Doctor's Signature _____ Date: _____
required