

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____



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 <i>no symptoms</i> : | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Throat † Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Lung † Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Heart † Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Other † _____ | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

◆ 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)