Food Allergy Action Plan

Student's Name _____ D.O.B _____Teacher_____

ALLERGY TO: _____

Asthmatic? □ Yes* □ No *High 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*:		□ Epinephrine □ Antihistamine
▪ 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 intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™0.3mg Twinject™ 0.15mg

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)