

Food Allergy Action Plan

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

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

Place
Child's
Picture
Here

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>		<u>Give Checked Medication**:</u>	
▪ If a food allergen has been ingested, but <i>no symptoms</i> :		<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine	
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat†	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung†	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other†	_____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:		<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine	

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ 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. _____ Phone Number: _____

3. Parent _____ Phone Number(s) _____

4. Emergency contacts:
Name/Relationship _____ Phone Number(s) _____

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

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

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ (Required) Date _____