

Food Allergy Action Plan

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

Place
Child's
Picture
Here

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"/> 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 _____ Date _____

(Required)

***Parents are asked to write their INITIALS in the space next to their preference to answer the questions below, please.

1. My child is required to sit at the nut-safe table at lunch:

Yes _____ No _____

2. My child requires a nut-safe classroom:

Yes _____ No _____