Food Allergy Action Plan

Student's Name: _____ **D.O.B:** _____ Attach

Teacher: _____ Picture

ALLERGY TO: _____ Here

_____

Asthmatic Yes* No *Higher risk for severe reaction

*** STEP 1: TREATMENT ***

Symptoms: **(To be determined by physician authorizing treatment)	**Give Checked Medication:**
* 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™ 0.3 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. _____
3. _____

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 Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)