Food Allergy Action Plan

Place Child's Picture Here

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 *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

◆ 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)