Food Allergy Action Plan

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™0.15mg**

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_____