FOOD ALLERGY ACTION PLAN

Student's Name________________________________ DOB: ______________ Teacher: ____________________

ALLERGY TO: ____

<u>Asthmatic</u> YES* ☐ NO ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

**TO BE COMPLETED BY PHYSICIAN **

Symptoms:	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 €** Thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
***Other** ________________________________	☐ Epinephrine	☐ Antihistamine
*If reaction is progressing (several of the above areas affected)	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change

€ Potentially life-threatening

<u>DOSAGE:</u>

<u>Epinephrine:</u> inject intramuscularly (circle one) EpiPen EpiPen Jr (see reverse side for instructions)

<u>Antihistamine</u>: medication______________________ dose_____________________ route_______________________

<u>Other</u>: medication___________________________ dose______________________ route_______________________

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

STEP 2: EMERGENCY CALLS

EMERGENCY PERSONNEL MUST BE CALLED IF EPINEPHRINE IS GIVEN

Call 911: State that an allergic reaction has been treated, what medication has been used and additional epinephrine may be needed

Physician Name: ____ phone ______________________________

<u>Emergency Contacts:</u>

Name/Relationship	Phone Number (s)
1) ______________________________	1) ______________________________
2) ______________________________	2) ______________________________
3) ______________________________	3) ______________________________

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

Parent/Guardian Signature: ____ Date: _________________________

Doctors Signature: ____ Date: _________________________

(Required)