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**:**	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	______________________________	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

**To be determined by physician authorizing treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (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)