FOOD ALLERGY ACTION PLAN

Place Child's Picture Here

Student 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
Stomach: 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

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

DOSAGE

Epinephrine: inject intramuscularly (please circle one) EpiPen® 0.3mg EpiPen® Jr. 0.15 mg

Benadryl/Antihistamine (Must be given by the nurse only) _____

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. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr.: _____ at _____
3. Emergency Contact Information

Name/Relationship	Phone Number(s)	
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

(Required)