



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: <small>(To be determined by physician authorizing treatment)</small>	
If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Stomach: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat:** Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung:** Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart:** Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other: _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (please circle one)

EpiPen® 0.3mg
AUVI-Q® 0.3mg

EpiPen® Jr. 0.15 mg
AUVI-Q® 0.15mg

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

- Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- Dr.: _____ at _____
- Emergency Contact Information

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

Parent/Guardian Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

(Required)