

Food Allergy Action Plan

Student's Name _____ D.O.B. _____

Allergy to: _____

Asthmatic ___ Yes ___ No

STEP 1: TREATMENT

Symptoms (‡ Potentially life -threatening)

Give Checked Medication

(to be determined by physician treatment)

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

‡ Potentially life -threatening

Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr Twinject 0.3 mg Twinjet 0.15 mg

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

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. Call parents. Contact numbers are on attached form.

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)