Food Allergy Action Plan

Form E

(NEED ONLY BE COMPLETED IF YOUR CHILD HAS ALLERGIES)

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

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

DOSAGE

Epinephrine: inject intramuscularly _____

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_____