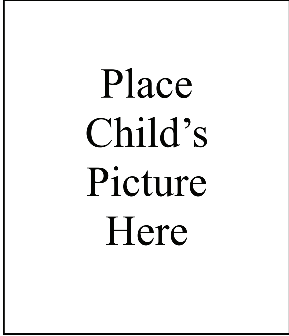
Food Allergy Action Plan



____________________ Student'sName   ____________ Date of Birth   ____________ Teacher

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 if progressing (several of the above areas affected), give…		□ EpiPen	□ Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening.
**Medication to be determined by physician authorizing treatment.

Dosage:
Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Location of EpiPen/EpiPen Jr. (nurse, child, classroom, etc.)________________________

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 Numbers	
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 a medical facility!

Parent/Guardian Signature______________________________ Date____________

Doctor's Signature (required)______________________________ Date____________