Food Allergy Action Plan

Student's Name ______________________________ D.O.B: __________ Teacher: ____________________

ALLERGY TO: ____ School Attending ____________

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

♦ STEP 1: TREATMENT ♦

Symptoms:	**Give Checked Medication **:** (To be determined by physician authoring treatment. Please circle correct medication)	
■ 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
■ Gut – 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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr Twinjet™0.3 mg Twinject™0.15 mg (See reverse side for instructions)

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. ________________________________ Phone Number ________________________
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 AS PRESCRIBED OR CALL 911

Parent/Guardian Signature ________________________________ Date ________________

Doctor's Signature ________________________________ Date ________________