Food Allergy Action Plan

Place Child's Picture Here

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

ALLERGY TO: _____

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

◆ STEP 1: TREATMENT (to be completed by the physician) ◆

Symptoms:		**Give Checked Medication**:** ** (To be determined by physician authorizing treatment)	
• 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 ǂ	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung ǂ	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart ǂ	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other ǂ	_____	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject 0.15 mg
(see reverse side for instructions)

Antihistamine: give_____
medication/dose

I authorize and have trained the child to carry and self-medicate:

EpiPen® ☐ Yes ☐ No
Benadryl ☐ Yes ☐ No (1 dose as permitted by state code #c. 18A:40-12.6a to 18A:40-12.6d)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS (to be completed by the parent/guardian) ◆

1. Call 911 (or Rescue Squad:_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr._____ Phone Number:_____
3. Parent_____ Phone Number(s):_____
4. Emergency contacts:
   Name/Relationship Phone Number(s)
   a. _____ _____ _____
   b. _____ _____ _____

EVEN IF PARENT/GUARDIAN CANNONT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature: _____ Date_____

Doctor's Signature: _____ Date_____

(Physician Signature and Stamp Required)