St. Francis Area Schools

4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Food Allergy Action Plan

Place Student's Photo Here

ALLERGY TO _____

Student's Full Name _____ ☐ Male ☐ Female

Birthdate _____ School _____ Grade ____

Parent/Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Health Care Provider _____ Clinic _____

Emergency Contact _____ Relation _____ Phone _____

ASTHMATIC Yes ☐ (High risk for severe reaction) No ☐

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
• MOUTH	Itching and swelling of the lips, tongue or mouth
• THROAT*	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• SKIN	Hives, itchy rash and/or swelling about the face or extremities
• DIGESTIVE	Nausea, abdominal cramps, vomiting and/or diarrhea
• LUNG*	Shortness of breath, repetitive coughing and/or wheezing
• HEART*	Thready pulse/passing out

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

1. If only symptom(s) are _____
   _____ ,
   give _____ .
   Medication/Dose/Route

THEN CALL

2. Parent/Guardian or emergency contact at number above.
3. Health Care Provider, if indicated _____ at _____ .
   If condition does not improve within 10 minutes, follow steps for major reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptom(s) are _____
   _____ ,
   give _____ immediately.
   Medication/Dose/Route

IMMEDIATELY CALL

2. 911
3. Parent/Guardian or emergency contact at number above.

*Health Care Provider Signature _____ Date _____

Print Name _____ Phone _____

*Health Care Provider must sign for any medication needed.

I consent to the release of the information contained in this Food Allergy Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature _____ Date _____