

**ALBANY AREA SCHOOLS
Food Allergy Action Plan
2019-20**

Student Name: _____ DOB: _____ School/Grade: _____

Allergy to: _____

Asthmatic: No _____ Yes _____ (If yes, higher risk for severe reaction)

Student is allowed to self carry the medication(s) listed below: No _____ Yes _____

STEP 1: TREATMENT

Symptoms:

Give Medication: (X)
Epinephrine Antihistamine

- | | | |
|--|-------|-------|
| 1. If food allergen has been ingested, but no symptoms | _____ | _____ |
| 2. Mouth: itching, tingling, swelling of lips or tongue | _____ | _____ |
| 3. Skin: hives, itchy rash, swelling of face or extremities | _____ | _____ |
| 4. Gut: nausea, abdominal cramps, vomiting, diarrhea | _____ | _____ |
| 5. *Throat: tightening of the throat, hoarseness, cough | _____ | _____ |
| 6. *Lungs: shortness of breath, repetitive cough, wheeze | _____ | _____ |
| 7. *Heart: weak pulse, low blood pressure, faint, pale, cyanosis | _____ | _____ |
| 8. If reaction is progressing (several of above affected) | _____ | _____ |

* *Potentially life-threatening*

STEP 2: DOSAGE

Epinephrine: _____

Medication	Route	Dose	Frequency
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Antihistamine: _____

Medication	Route	Dose	Frequency
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Other: _____

STEP 3: EMERGENCY CALLS & MONITORING

1. Call 911. State an allergic reaction has been treated and that additional epinephrine may be needed. Note time epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

2. Call parent or guardian. Even if parent or guardian cannot be reached, take child to the Emergency Room.

Physician signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Health Assistant signature: _____ Date: _____

Licensed School Nurse signature: _____ Date: _____

HEALTH OFFICE: please note if 1 or 2 Epinephrine injectors provided: _____

* A clinic form with this information may be substituted for this form.