Food Allergy Action Plan

School Year _____

Student's Name: _____ Date of Birth:_____ Teacher: _____

Allergy to: _____

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

Place Child's Picture Here

Step I: 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 is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

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

Dosage

Epinephrine: inject intramuscularly ☐ EpiPen ☐EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____
medication/does/route

Other: give _____
medication/does/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 Number(s)	
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 medical facility!

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date:_____
(Required)

Revised 3/11 (green)