**ALBANY AREA SCHOOLS**
**Food Allergy Action Plan**
**2023-24**

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

Antihistamine: _____
Medication Route Dose Frequency

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.