New Hartford Public Schools
Educating for Excellence

Place Child's Picture Here

Food Allergy Action Plan

Name _____ **Dob** _____ **Teacher** _____

Allergy To: _____

Asthmatic *(circle one)* Yes* No *Higher risk for severe reaction

♦ **STEP 1: TREATMENT** ♦

Symptoms		**Give Checked Medication**:**	
▪ 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 †	Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
▪ Other †	_____	□ Epinephrine	□ Antihistamine
▪ If reaction is progressing (several of the above areas effected) give:		□ Epinephrine	□ Antihistamine

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

DOSAGE

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

Antihistamine: give _____
(*medication/dose/route)*

Other: give _____
(*medication/dose/route)*

♦ **STEP 2: EMERGENCY CALLS** ♦

1. **Call 911 -** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Dr**. _____ **at** _____
3. **Emergency Contacts**: **Name/Relationship** **Phone Numbers**

   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 Signature _____ **Date** _____
(required)