

# FOOD ALLERGY ACTION PLAN



**Student Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

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

## STEP 1: TREATMENT

<u>Symptoms:</u>	<u>Give Checked Medication:</u> <small>(To be determined by physician authorizing treatment)</small>	
If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Stomach: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat:** Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung:** Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart:** Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other: _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

## DOSAGE

**Epinephrine:** inject intramuscularly (please circle one)

EpiPen® 0.3mg  
AUVI-Q® 0.3mg

EpiPen® Jr. 0.15 mg  
AUVI-Q® 0.15mg

**Benadryl/Antihistamine** (Must be given by the nurse only) \_\_\_\_\_

Medication/Dose/Route

### **Physician Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that they can self-administer Epinephrine safely and effectively, and may carry and use this medication independently at school.

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## 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 Contact Information

Name	Relationship	Phone Number(s)
_____	_____	_____
_____	_____	_____

Doctor's Signature: \_\_\_\_\_  
(Required)

Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_  
(Required)

Date: \_\_\_\_\_

