FOOD ALLERGY ACTION PLAN

Student's Name ____________________________ DOB _________ Grade________
ALLERGY TO:____
<u>Asthmatic</u> YES* NO * Higher risk for severe reaction

<u>Step 1: TREATMENT</u>

<u>Symptoms</u>		**<u>Give Checked Medication</u>**	
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 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 BP, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected) give:		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. **potentially life threatening.*

<u>Dosage</u>
Epinephrine: give____
(dose/route)

Antihistamine: give ____
(medication/dose/route)

Other: give ____
(medication/dose/route)

<u>Step 2: EMERGENCY CALLS</u>

1. Call 911. State that an allergic reaction has been treated, and additional Epinephrine may be needed.

2. Dr. ____________________________________ Phone _______________________

3. Emergency Contact: _________________________ Phone____________________

Parent/Guardian Signature_______________________________ Date_____________
Doctor's Signature ____________________________________ Date_____________
(Required)