**Food Allergy Action Plan** 

| Student's<br>Name:   | D.O.B:Teacher:  |   | Place           |
|--|---|---|-----------------|
|  |   |   | Child's         |
| ALLERGY TO:  |   |   | Picture         |
| Asthmatic Yes* No *Higher risk for severe reaction   |   |   | Here            |
| ◆ STEP 1: TREATMENT ◆  |   |   |                 |
| Symptoms:  |   | Give Checked Medication**:  **(To be determined by physician authorizing treatment) |                 |
| ■ If a fo  | ood allergen has been ingested, but no symptoms:                      | ☐ Epinephrine   | ☐ Antihistamine |
| ■ Mout   | h Itching, tingling, or swelling of lips, tongue, mouth               | ☐ Epinephrine   | ☐ Antihistamine |
| <ul><li>Skin</li></ul>   | Hives, itchy rash, swelling of the face or extremities                | ☐ Epinephrine   | ☐ Antihistamine |
| ■ Gut  | Nausea, abdominal cramps, vomiting, diarrhea                          | ☐ Epinephrine   | ☐ Antihistamine |
| ■ Throa  | t† Tightening of throat, hoarseness, hacking cough                    | ☐ Epinephrine   | ☐ Antihistamine |
| <ul><li>Lung</li></ul>   | † Shortness of breath, repetitive coughing, wheezing                  | ☐ Epinephrine   | ☐ Antihistamine |
| ■ Heart  | † Weak or thready pulse, low blood pressure, fainting, pale, blueness | ☐ Epinephrine   | ☐ Antihistamine |
| <ul><li>Other</li></ul>  | †   | ☐ Epinephrine   | ☐ Antihistamine |
| ■ If rea   | ction is progressing (several of the above areas affected), give:     | ☐ Epinephrine   | ☐ Antihistamine |
| †Potentially life-threatening. The severity of symptoms can quickly change.  |   |   |                 |
| (see reverse side for instructions)  Antihistamine: give   |   |   |                 |
| Other: give medication/dose/route  |   |   |                 |
| IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.  ◆ 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 Phone Number:  |   |   |                 |
| 3. Parent  | Phone Number(s)   |   |                 |
| 4. Emergency contacts: Name/Relationship Phone Number(s)   |   |   |                 |
| a  | 1.)   | 2.)   |                 |
| b  | 1.)   | 2.)   |                 |
| EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!                                  |   |   |                 |
| Parent/Guardia   | n's Signature   | Date  |                 |
| Doctor's Signat  | ure(Required)   | Date  |                 |