FOOD ALLERGY ACTION PLAN

Students Name: _____ DOB_____
Allergy To:_____
Asthmatic: Yes _____ No_____

Step 1: Treatment

Symptoms:		**Give Checked Medication:** To Be Determine by Physician
• 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
•Lungs†	Shortness of breath, repetitive coughing, wheezing	_Epinephrine _Antihistamine
•Heart†	Thready pulse, low blood pressure, fainting, pale Blueness	_Epinephrine _Antihistamine
•If reaction is progressing (several of the above areas affected)		_Epinephrine _Antihistamine

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

Dosage:
Epinephrine: inject intramuscularly EpiPen _____ EpiPen Jr._____
Antihistamine: _____
Medication/dose/route
Other: _____
Medciation/dose/route

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

Step 2: Emergency Calls

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

Emergency Contact(s):

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

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TRANSPORT CHILD TO HOSPITAL

Parent/Guardian signature:_____ Date_____

Doctor's Signature:_____ Date_____