

# Food Allergy Action Plan

Student's

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

Place  
Child's  
Picture  
Here

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

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

## ◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>		<u>Give Checked Medication**:</u>	
		**(To be determined by physician authorizing treatment)	
▪	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
▪	Gut 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† Weak or 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 (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg  
(see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**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/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

(Required)