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FOOD ALLERGY ACTION PLAN

Student Name: ______________________________ D.O.B.: _______________

Allergy to: ____

Weight: ___________ Asthma: _____ Yes (high risk for severe reaction) _____ No

Extremely reactive to the following foods:____

____

_____ Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten

_____ Give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noticeable

Any SEVERE SYMPTOMS after suspected or known ingestion

One or more or the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or a combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (eyes, lips)

GUT: Vomiting, diarrhea, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

Call 911

Give additional medications (antihistamine or inhaler if asthma)

**Antihistamines and inhalers/bronchodilators are not to be depended on to treat a severe reaction.*

USE EPINEPHRINE.