

FOOD ALLERGY ACTION PLAN

Student's Name _____ DOB _____ Grade _____

ALLERGY TO: _____

Asthmatic YES* NO * Higher risk for severe reaction

Step 1: TREATMENT

Symptoms

Give Checked Medication

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.*

Dosage

Epinephrine: give _____

(dose/route)

Antihistamine: give _____

(medication/dose/route)

Other: give _____

(medication/dose/route)

Step 2: EMERGENCY CALLS

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)