

Food Allergy Action Plan

Student's Name: _____ D.O.B _____

Allergy to: _____

Asthmatic: ☐ NO ☐ YES * * Higher Risk for Severe Reaction

Emergency Contact: Family

Parent/Legal Guardian's Name: _____

Phone Number: 1). _____ 2). _____

Address: _____

Doctor

Doctor's Name: _____ Address: _____

Phone: _____ Fax: _____

TREATMENT

Symptoms:

If a food allergen has been ingested, but *not symptoms*:

Mouth - Itching, tingling or swelling of lips, tongue, mouth

Skin - Hives, swelling of the face or extremities

Gut - Nausea, abdominal cramps, vomiting, diarrhea

Throat - Tightening of throat, hoarseness, hacking cough

Lung - Shortness of breath, repetitive coughing, wheezing

Heart - Thready pulse, low blood pressure, fainting, pale, blueness

Other _____

If reaction is progressing (several of the above areas affected), give

Give Checked Medication:**

☐ Epinephrine ☐ Antihistamine

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The severity of symptoms can quickly change.

Dosage

Epinephrine: Inject intramuscularly (Check One) ☐ Twinject ☐ EpiPen ☐ 0.3mg ☐ 0.15 mg

Antihistamine: give _____

Medication/dose/route

Oral: (Check One) ☐ Benadryl ☐ 12.5mg ☐ 25mg ☐ 50mg

Special Instructions: To be used immediately following an accidental ingestion of _____

If your symptoms have not improved within about 5 minutes since first injection, give second injection.

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

TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

