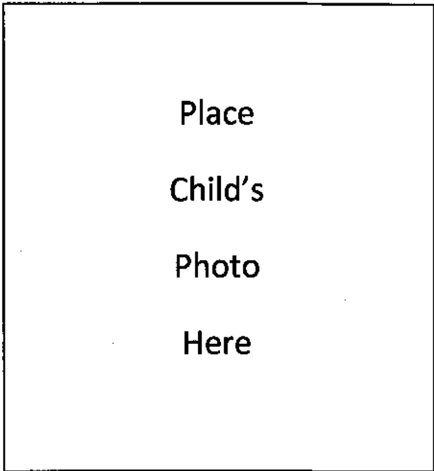
Food Allergy Action Plan



Student's Name:_______________________ DOB__________ Class _____

ALLERGY TO: ____

LOCATION OF ALLERGY MEDS ____________________________

Asthmatic? NO YES* *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give Circled Medication (as authorized by physician):

	Symptoms	Give Circled 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^**: Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
*	Other	Epinephrine	Antihistamine
*	If reaction is progressing (several of the above areas affected) give:	Epinephrine	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 0.15mg

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.

EMERGENCY TRANSPORT TO HOSPITAL IS MANDATORY ANYTIME EPINEPHRINE HAS BEEN ADMINISTERED. PROCEED IMMEDIATELY TO STEP 2 FOR EMERGENCY CALLS.

Physician's Signature______________________________ Date___________

STEP 2: EMERGENCY CALLS

1. Call 911 and state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________________ Phone______________________________
3. Parent ______________________________ Home Phone______________________________
   Cell Phone ______________________________
   Work/Other Phone ______________________________
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!

****One copy of this form must be stored with each Epi-pen/Twinject****

Illustrated instructions for Epi-pen and Twinject to be inserted here on paper copy

Allergy Information Sheet for Teachers

(To be kept in Plan Book)

Student's Name____
Teacher's Name/Class___________________________________
Location of emergency medications:

____

If an allergic reaction is suspected, seek medical help immediately. Initiate the Food Allergy Action Plan which accompanies the medications.

Allergy History:

Allergen:	Past reactions due to (circle one):
____________________	ingestion / touch / airborne
____________________	ingestion / touch / airborne
____________________	ingestion / touch / airborne
____________________	ingestion / touch / airborne
____________________	ingestion / touch / airborne

General Information:

Is your child aware of the symptoms of an allergic reaction? _________
Is your child aware of the dangers if an allergen is ingested? _________
If uncertain of a food, would your child be likely to:
(Circle one)

- Definitely refuse it
- Ask an adult if it is OK to eat
- Eat it, if it looked OK
- Eat it, no matter how it looked

If your child felt unwell, would he/she seek help? _________ If not, please comment:

____

Is there any other information you feel would be helpful for us to know about your child?

____

____

Parent's Signature __________________________________ Date______________

Teacher's Signature__________________________________ Date______________