Food Allergy Action Plan

Student’s Name: ___________________________ D.O.B: ___________ Teacher: _______________

ALLERGY TO: _____________________________________________________________

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

◆ STEP 1: TREATMENT ◆

Symptoms:
- If a food allergen has been ingested, but no symptoms:
- Mouth: Itching, tingling, or swelling of lips, tongue, mouth
- Skin: Hives, itchy rash, 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

The severity of symptoms can quickly change. †Potentially life-threatening.

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: ___________________________ at ___________________________

3. Parents_________________________ 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 Signature ___________________________ Date ___________________________

Doctor’s Signature ___________________________ (Required) Date __________________________