Food Allergy Action Plan

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

ALLERGY TO:_____

Asthmatic (circle one) Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication:** (To be determined by physician authorizing treatment)	
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 the 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® 0.15 mg

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.

STUDENT HAS HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS: YES_____ NO_____

IF EPINEPHRINE AUTO-INJECTOR IS PRESCRIBED, CHECK ONE:

_____Student is **not** capable of self-administration.

_____Student is capable of self-administration, has been instructed in its use, and may carry Epinephrine auto-injector with him/her.

If epinephrine is given, EMS will be immediately contacted.

Physician's Signature _____ Date_____

Pleases print or stamp Name _____
Address _____
Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child, or from self-administration when certified by the physician.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Emergency Phone _____