

# FOOD ALLERGY ACTION PLAN

Date \_\_\_\_\_

According to your child's records, she/he has a food allergy. Please provide us with more information by completing this form and returning it to the school office.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First Middle

Place  
Child's  
Picture  
Here

**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, itching 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

### Give Checked Medication\*\*:

\*\* (To be determined by physician authorizing treatment)

- |                                      |  |                                |
|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |

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

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) -see reverse side for instructions.

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.**

## ❖ 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: \_\_\_\_\_

3. Parent \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

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's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)