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 †: ________________________________________________________________

Give Checked Medication**: □ EpiPen  □ Antihistamine

- If reaction is progressing (several of the above areas affected), give
- EpiPen  □ Antihistamine

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

DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen  EpiPen Jr. (see reverse side for instructions)

Antihistamine: give__________________________________________________________

Other: give____________________________________________________________________________________

◆ 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. __________________________________________ at _____________________________

3. Emergency contacts:

Name/Relationship  Phone Number(s)

a. __________________________________________  1.)________________________  2.) ______________________

b. __________________________________________  1.)________________________  2.) ______________________

c. __________________________________________  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_________________________________________________________  Date_______________

(Required)
TRAINED STAFF MEMBERS

1. ____________________________________________________                   Room ________

2. ____________________________________________________                   Room ________

3. ____________________________________________________                   Room ________

EPIPEN® AND EPIPEN® JR. DIRECTIONS

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).

- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

- Once EpiPen® is used, call the Rescue Squad. State additional epinephrine may be needed. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.**