



## Food Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Class: \_\_\_\_\_

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, blue
- Other: \_\_\_\_\_
- If reaction is progressing (several of the above areas affected)

#### Give Checked Medication:

- EpiPen    Antihistamine
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The severity of symptoms can quickly change. + Potentially life threatening

#### Dosage:

**Epinephrine:** inject intramuscularly (check one)     EpiPen     EpiPen Jr.

**Antihistamine:** give \_\_\_\_\_  
medication/dose

**Other:** give \_\_\_\_\_  
medication/dose

### \*STEP 2: EMERGENCY CALLS \*

1. Call 911 and state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Call Dr.** \_\_\_\_\_ **at** \_\_\_\_\_
3. Emergency contacts:  
 \_\_\_\_\_ @ \_\_\_\_\_  
 \_\_\_\_\_ @ \_\_\_\_\_

I hereby authorize The Children's Corner to post this information in my child's classroom.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
(Date)