

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:

Give Checked Medication:**

To be determined by physician authorizing treatment

- | | | | | | | | | | | | | | | | | | |
|--|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|---------------------------------|--|
| <ul style="list-style-type: none"> ▪ If a food allergen has been ingested, but <i>no symptoms</i>: ▪ 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 | <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> EpiPen</td> <td><input type="checkbox"/> Antihistamine</td> </tr> </table> | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
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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 _____ medication/dose/route

Other: give _____ medication/dose/route

◆ 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 _____
(Required)

Date _____

TRAINED STAFF MEMBERS

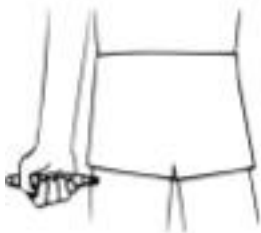
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|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

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.*