Food Allergy Action Plan

Student's Name:_____D.O.B._____Teacher:_____
ALLERGY TO:_____
Asthmatic Yes No

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**
*	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	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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.
Twinject 0.3 mg Twinject 0.15 mg
(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. Emergency contacts:

Name/Relationship	Phone Numbers
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:_____