# Food Allergy Action Plan

Student's
Name _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____ School Attending _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ♦ STEP 1: TREATMENT ♦

| **Symptoms:** | **Give Checked Medication **:** (To be determined by physician authoring treatment. Please circle correct 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 |

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

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen®Jr Twinjet™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. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number _____
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 AS PRESCRIBED OR CALL 911**

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____