NORTH WALL
SCHOOLS

Food Allergy Action Plan

Student's Name:_____D.O.B:_____Teacher:_____
ALLERGY TO:_____

Place Child's Picture Here

Asthmatic Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:	**Give checked Medication**:** To be determined by physician authorizing treatment	
• 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 extremities	Epinephrine	Antihistamine
• **Gut** Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• **Throat** Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
• **Heart** Weak or thread pulse, low blood sugar, fainting, pale, blueness	Epinephrine	Antihistamine
• **Lung** Shortness of breath, repetitive cough, wheezing	Epinephrine	Antihistamine
• **Other** _____	Epinephrine	Antihistamine
• If reaction is progressing (several of the above areas affected), give:	Epinephrine	Antihistamine

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

DOSAGE

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

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

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. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____
4. Emergency contacts:

Name/Relationship Phone Number(s)

a. _____ 1.)_____ 2.) _____
b. _____ 1.)_____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____
Doctor's Signature_____ Date_____