Food Allergy Action Plan

Place Child's Picture Here

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

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, blueness
- Other† _____
- If reaction is progressing (several of the above areas affected), give

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

Give Checked Medication:**
**(To be determined by physician authorizing treatment)

☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
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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

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: _____ at_____

3. Parents_____ 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 Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Blessed Sacrament School
Allergy History Form

Student's Name: _____ Date: _____

Parent/Guardian: _____ Homeroom/Grade: _____

Allergies: _____

_____

1) When and how did you first become aware of the allergy?

2) How would you rate the severity of this student's allergy? (please circle)

   (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

3) When was the last time your child had a reaction?

4) Please describe the signs and symptoms of the reaction.

5) What medical treatment was provided and by whom?

6) If medication is required while your child is at school, an Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian. Please list medications below:

7) Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

Parent or Guardian: _____ Date: _____

Print Name: _____ Contact Number: ( ) _____