

Food Allergy Action Plan

ALLERGY TO: _____

Students Name: _____ DOB _____

Teacher: _____

ASTHMATIC: YES * NO * **HIGH RISK FOR REACTION**



SIGNS OF ALLERGIC REACTIONS

Please check below the medications your child must take during an allergic reaction

SYMPTOMS

- **If exposed to an allergen, but no symptoms** give...
- **Mouth:** itching and swelling of the lips, tongue, or mouth give...
- **Throat*:** itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- **Skin:** hives, itchy rash and/or swelling about the face or extremities
- **Gut:** nausea, abdominal cramps, vomiting and/or diarrhea
- **Lung*:** shortness of breath, repetitive coughing, and/or wheezing
- **Heart*:** "thready" pulse, "passing out"

Give Checked Medication

- EpiPen Benadryl
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*** ALL ABOVE SYMPTOMS PERTAINING TO THROAT, LUNG AND/OR HEART CAN POTENTIALLY PROGRESS TO LIFE THREATNING SITUATION**

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _____ give
_____ (Medication, Dose and Route)

2. Then Call: Mother _____ Father _____ or
emergency contacts.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptoms are _____ give
_____ immediately!
(Medication, Dose and Route)

2. Call 911 (ask for advanced life support) if you have given an Epi-Pen injection. *Be ready to give an additional dose of Epinephrine in 15 minutes if ambulance has not arrived.*

3. Then Call: Mother _____ Father _____ or emergency
contacts.

Emergency Contacts

First: _____

Second: _____

Third: _____

Relationship: _____

Relationship: _____

Relationship: _____

Phone: _____

Phone: _____

Phone: _____

Parents Signature: _____ Date: _____