#110

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:		**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 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†	Weak or 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

†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 (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: _____

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_____
(Required)

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HEALTH HISTORY - Caring for Students with Allergies

Student Name: _____ Date of Birth: _____ Grade: _____

Primary Health Concern: _____

Secondary Health Concern(s): _____

Healthcare Provider's Name: _____ Phone: _____

Diagnosis (note specific allergens): _____

At what age was the student diagnosed with an allergy? _____

_____

What symptoms led to the diagnosis? _____

_____

What are the student's usual symptoms? _____

_____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last allergic reaction? _____

Has the student been hospitalized as a result of an allergic reaction?

☐ Yes How many times? _____ ☐ No

Does the student have an early awareness of the onset of an allergic reaction? _____

What treatment does the student usually require for an allergic reaction? _____

Has the student experienced an allergic reaction at school before? _____

If so, please describe the latest incident: _____

_____

Does the student have asthma?: ☐ Yes ☐ No (Asthma can increase the severity of a reaction) How have previous allergic reactions affected his/her asthma? _____

_____

Is the student self-directed? ☐ Yes ☐ No

Is there anything else that the school should know to take the best care we can of your student?

_____

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis? ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____