FOOD ALLERGY ACTION PLAN *BUS#_____*

STUDENTS NAME_____GR./TEACHER_____

ADDRESS_____ALLERGIC TO_____

ASTHMATIC-YES*____ NO_____ *Higher risk for severe reaction *Upd. 4/17*

SYMPTOMS:

	GIVE CHECKED MEDICATION**
• If a food allergen has been ingested, but no symptoms	
• 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	__Epinephrine __Antihistamine
Pale, blueness	__Epinephrine __Antihistamine
• Other*_____ _____	__Epinephrine __Antihistamine
• If reaction is progressing (several of above areas affected)	__Epinephrine __Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one)

Epi-Pen Epi-Pen Jr. Twinject 0.3 mg Twinject 0.15 mg

Antihistamine: give_____Other: give_____

Medication/Dose/Route ***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:_____**
4. **Emergency contacts: Name_____ Phone Number_____**
5. **Emergency contacts: Name_____ Phone Number_____**

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

PARENT/GUARDIAN'S SIGNATURE_____ DATE:_____

DOCTOR'S SIGNATURE_____DATE:_____

REQUIRED