



Food Allergy Action Plan

Student's name: _____ D.O.B. _____ Class _____

Allergy to: _____
Asthmatic Yes* _____ No _____ *Higher risk of severe reaction

STEP 1: TREATMENT

Symptoms:

- If a food allergen has been ingested, but no symptoms:
 - Mouth Itching, tingling, or swelling of lips, tongue or mouth
 - Skin Hives, itchy rash, swelling of 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, blueness
 - Other† _____
- † potentially life threatening The severity of symptoms can quickly change.

Give Checked Medication

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Medication |

Medication Dosage:

Epinephrine: inject IM (circle one) EpiPen® EpiPen® Jr. Twinject™0.3mg Twinject™0.15mg Auvi-Q™0.15mg Auto injector Auvi-Q™0.3mg Auto injector

Antihistamine: give _____
Medication/Dosage/Route

Other: _____
Medication/Dosage/Route

STEP 2: EMERGENCY CALLS

Call 911 [or **Hatzalah** (718 or 212)230-1000; (718 or 212) 387-1750]. State that an allergic reaction has been treated, and additional epinephrine may be needed.

Dr. _____ at _____

Emergency Contacts:

<u>Name/Relationship</u>	<u>Phone Numbers</u>
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/ Stamp _____ **Date** _____

(Required)