Food or Insect Allergy Action Plan

PLACE CHILD'S PICTURE HERE

Student's Name:_____ D.O.B.:_____ Homeroom Teacher:_____ Grade:____

Allergic to: _____

Asthmatic Yes*☐ No ☐ *Denotes 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, or insect has stung student 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 thread 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

Student has been trained to self-administer epi-pen and may carry on person: (check one) yes_____ no_____

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(s)_____ Phone Number(s): _____
4. Emergency contacts:

   Name/Relationship Phone Number(s)

   a. _____ _____

   b. _____ _____

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

Parent's/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)