Food / Insect Allergy Action Plan

Student's Name:________________________________Date of Birth:_______________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*	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

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

DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see page 2 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 than an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr.____at_______________________________

3. Emergency contacts:
Name/Relationship Phone Number(s)

a. _________________________________ 1)________________________ 2)_________________________

b. _________________________________ 1)________________________ 2)_________________________

c. _________________________________ 1)________________________ 2)_________________________

Even if Parent/Guardian cannot be reached, do not hesitate to medicate or take child to medical facility.

*Parent/Guardian Signature*____ *Date:*_____________________

Physician's Signature *(required)*____ *Date:*_____________________

Reviewed by School Nurse:____ Date:_________________________