FOOD ALLERGY ACTION PLAN

Student Photo

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 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 quickly change. **Potentially life-threatening.

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3mg Twinject ™ 0.15mg

Antihistamine: give _____
medication/dose/route

Other: give_____
medication/dose/route

Student may carry above medications ☐ Yes ☐ No Student may self administer above medications ☐ Yes ☐ No

STEP 2: EMERGENCY CALLS

1. Call 911. State that 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_____
(Required)

As the authorizing physician, I am willing to accept direct communication from the person dispensing and administering the above medication.

Doctor's signature_____ Date_____
(Required)

To Parent/Guardian/Practitioner: In accordance with state law, school personnel may give prescription medication to students only with complete directions from a practitioner and signed consent by the student's parent/guardian. School personnel may give non-prescription medication to students only with directions and signed consent from parents/guardians. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any other container or package other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____
4. _____ Room _____