

**Food Allergy & Anaphylaxis Action Plan**

**Name: D.O.B.: / / Allergy to:**

**Asthma:**  Yes (higher risk for a severe reaction)  No

**Place Student’s Picture Here**

**Extremely reactive to the following foods: THEREFORE:**

 If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

 If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion:**

**One or more** of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body

Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, diarrhea, crampy pain

**1. INJECT EPINEPHRINE IMMEDIATELY**

2. Call 911

3. Begin monitoring (see box below)

4. Give additional medications:\*

-Antihistamine

-Inhaler (bronchodilator) if asthma

\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

**MILD SYMPTOMS ONLY:**

MOUTH: Itchy mouth

SKIN: A few hives around mouth/face, mild itch

GUT: Mild nausea/discomfort

**Medications/Doses**

**1. GIVE ANTIHISTAMINE**

2. Stay with student; alert healthcare professionals and parent

3. If symptoms progress (see above), USE EPINEPHRINE

4. Begin monitoring (see box below)

Epinephrine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antihistamine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic):

 **Monitoring**

***Stay with student; Monitor status continuously***. Tell EMS epinephrine was given.

**Does this student have physician authorization to self-administer this medication and to carry this medication on his/her person?** **Yes No**

**Parent/Guardian Signature Date Physician/Health Care Provider Signature Date**

**School Nurse/Health Coordinator Signature Date**

**Parent/Guardian must RETURN this form to the school nurse or health coordinator.**

**Emergency Contact Information:**

Parent/Guardian: Phone:

Physician: Phone:

**Other Emergency Contacts:**

Name/Relationship: Phone:

Name Relationship: Phone: