Food ALLERGY ACTION PLAN

Student Name_____ School Year_____

Date of Birth___/___/___ Building/Grade_____ Teacher_____

Allergy to:_____
Does student also have asthma: YES / NO

Emergency Contact Information

Parent/Guardian_____ Relationship_____ Phone_____

Alternate Contact_____ Relationship_____ Phone_____

Primary Physician_____ Phone_____ Fax_____

Preferred Hospital_____

Action Plan

Symptoms:	**Give checked Medication:**
If child has ingested allergen but has *NO symptoms*:	__Epinephrine __Antihistamine
Mouth-Itching, tingling, swelling of lips/tongue	__Epinephrine __Antihistamine
Skin-Hives, itching/rash, swelling	__Epinephrine __Antihistamine
Throat-Tightening, hoarseness, hacking cough	__Epinephrine __Antihistamine
Lungs-Shortness of breath, repetitive coughing, wheezing	__Epinephrine __Antihistamine
Heart-Thready pulse, low blood pressure, fainting, pale/blue	__Epinephrine __Antihistamine
Other:_____	__Epinephrine __Antihistamine

Dosage:

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr Auvi-Q____mg Twinject_____mg

Antihistamine:_____
Medication/Dosage/Route

Other:_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

Is there any additional information you would like the school to know regarding your child's allergy?

A signed authorization form, with a physician signature, is required for any medication your student may need while at school. Please ask your school nurse if you need assistance with getting the necessary documentation. If your student's medications or information changes please update the school as soon as possible.

Parent/Guardian Signature_____ Date_____

School Nurse Signature_____ Title_____ Date_____