Alpine Academy of Rockford

Food Allergy Action Plan

Name_____DOB_____Grade_____

ALLERGY_____

Asthmatic *Yes □ No □ *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give Checked Medication:**
(To be determined by physician authorizing treatment-see medication administration)

□ 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	±Weak or 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

±Potentially life threatening. The severity of symptoms can quickly change.

Dosage

Epinephrine: Inject intramuscularly (circle one) Epi Pen®, Epi Pen® Jr., Twinject ® 0.3mg, Twinject ®0.15 mg.
(See reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone _____

3. Parent _____ Phone _____

4.Emergency contacts:

	Name/Relationship		Phone Numbers		Phone Numbers
a.	_____	1.	_____	2.	_____
b.	_____	1.	_____	2.	_____
c.	_____	1.	_____	2.	_____

EVEN IF THE PARENT CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE THE CHILD TO A MEDICAL FACILITY

Parent Signature _____ Date _____

Doctor's Signature _____ Date _____
Required Signature

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