FOOD ALLERGY ACTION PLAN

Name: ____ Date of Birth: _____________

Allergy to: ____

Weight: __________ lbs. Asthma: _______ Yes (higher risk for a severe reaction) or ________ No

Extremely reactive to the following foods: ____

THEREFORE:

______, if checked, give epinephrine auto-injector for ANY symptoms if the allergen was *likely* eaten or exposed to allergen.

______, if checked, give epinephrine auto-injector immediately if the allergen was *definitely* eaten, even if no symptoms 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 area:
Skin: Hives, itchy rashes, swelling (i.e., eyes, lips)
Gut: Vomiting, crampy pain

PLAN

1. **INJECT EPINEPHRINE AUTO-INJECTOR IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications: *
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthmatic

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

Mild symptoms only:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

PLAN

1. **GIVE ANTIHISTAMINE**
2. Stay with student: alert healthcare professionals and parent
3. IF symptoms progress (see above), USE EPINEPHRINE AUTO-INJECTOR
4. Begin monitoring

MEDICATIONS/DOSES
Epinephrine auto-injector (brand and dose): ____

Antihistamine (brand and dose): ____

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

MONITORING

Stay with the student, alert healthcare professionals and the parent. **Tell rescue squad epinephrine auto-injector was given; request an ambulance with epinephrine.** Note time when epinephrine auto-injector was administered. A second dose of epinephrine auto-injector can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. **Treat student even if parents cannot be reached.**

____ ______________________________
Parent/Guardian Signature Date

____ ______________________________
Physician/Healthcare Provider Signature Date

Form and instruction must be signed by physician to be completed and the diocesan medication form is required for the student.

A food allergy response kit should contain at least **two doses** of epinephrine auto-injector, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

This is the responsibility of the teacher of the student to bring medication/administer medication if needed and to also bring emergency medical contact information.

CONTACTS:

CALL 911

Physician: ____ Phone: _______________________________

Parent/Guardian: ____ Phone: _______________________________

Other Emergency Contacts:

Name/Relationship: ______________________________________ Phone: _______________________________

Name/Relationship: ______________________________________ Phone: _______________________________

References:
Allergy ready, https://www.allergyready.com/
FARE, https://www.smiths-medical.com/products/patient-monitoring