ST. JOSEPH CATHOLIC SCHOOL
Excellence through Worship, Study, and Service

Food Allergy Action Plan

Name: _____ Date of Birth: _____

Allergy to: _____

Weight: _____lbs. Does your child have Asthma: Yes No

Extremely reactive to the following foods: _____

_____Give epinephrine for ANY symptoms if the allergen was likely eaten

_____Give epinephrine immediately if the allergen was certainly 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 areas:

Skin: Hives, itchy rashes, swelling (e.g., eyes, lips) **Gut**: Vomiting, crampy pain

PLAN:

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

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

Any mild symptoms after suspected or known ingestion: *one or more of the following:*

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/guardian
3. IF symptoms progress (see above), USE EPINEPHRINE
4. Begin Monitoring

Medications/Doses
Epinephrine (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 complete 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: _____