Food / Insect Allergy Action Plan

Student's Name:________________________________Date of Birth:_______________Teacher_______
Allergy to:_____________________________________ Asthmatic: ☐ Yes* ☐ No
Higher risk for severe reaction

Step 1: Treatment

Symptoms		Give Checked Medication** ** To be determined by physician authorizing treatment	
• 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*	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

The severity of symptoms can change quickly. *Potentially life-threatening.

DOSAGE
Epinephrine: inject intramuscularly ____
Name of Medication

Antihistamine: ____
Medication / Dose / Route

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

Step 2: Emergency Calls

1. Call 911 (or Rescue Squad:__________). State than an allergic reaction has been treated, and additional epinephrine may be needed.

2. Emergency contacts:
Name/Relationship Phone Number(s)

a. ________________________________ 1)________________________ 2)________________

b. ________________________________ 1)________________________ 2)________________

Even if Parent/Guardian cannot be reached, do not hesitate to medicate or take child to medical facility.

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.
☐ I certify that this child has a medical history of allergy and has been trained in the use of epinephrine, and is judged by me to be:

________capable of carrying and self-administering the listed medication(s),

________*NOT capable of carrying and self-administering the listed medication(s).*

*Parent/Guardian Signature*____ *Date:*______________

Physician's Signature (*required*)______________________________*Phone #:* __________________*Date:*________

*Reviewed by School Nurse:*____ *Date:*______________

*Refer to 504 coordinator if appropriate Updated 7/11