

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ 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 <i>no symptoms</i> : | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Throat† Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung† Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart† Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other† _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

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

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. TwinJect™ 0.3 mg TwinJect™ 0.15 mg (see reverse side for instructions)

Antihistamine: give _____ medication/dose/route

Other: give _____ 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 that an allergic reaction has been treated, and additional epinephrine may be needed.

1. Doctor _____ at _____
(Name) (Phone No. and Address)

2. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1) _____	2) _____
b. _____	1) _____	2) _____
c. _____	1) _____	2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

Doctor Name (print) _____

Principal's Signature _____

Food Allergy Questionnaire

In order to ensure the safety of your child at school and assist the classroom teacher and parents providing treats for classrooms, we would like to ask you to complete **in as much detail as possible**, information regarding foods that your child may have for snack and what foods your child must absolutely avoid.

If your child is allergic to nuts please specify which nuts they need to avoid and if there are any nuts they can safely eat. For example, allergy to walnuts and almonds but can have pecans and peanuts.

If your child is allergic to fruits please specify if it is the actual fruit only or if the allergy is to all forms of the fruit. Are artificial flavorings of the fruit acceptable? For example, allergy to apples but can have apple juice, applesauce or apple-flavored candy.

Please specify if the food product they are allergic to needs to be avoided all together or if a certain quantity is acceptable. For example, allergy to milk but can have 2 oz. a day of chocolate milk. Are frostings and glazes that contain milk or dairy o.k.?

Finally, please provide us with suggested snacks that you normally would provide at home; be very specific about what your child must avoid. If we have this information on file we can then compile a list of what food products need to be avoided in each classroom without providing names of the children with allergies. It is our hope that all children can have a fun and safe celebration of special events in their classroom.

Student name _____ Teacher _____

Food allergy to _____

Avoid food totally or limit the amount? _____

May have a limited amount (be specific) _____

My child may be in the same room with other children eating this food product? Yes No

My child needs to sit at a special lunch table free from _____ (foods)

My child **must avoid** the following prepared foods _____

My child **must avoid** the following baked goods _____

Snacks that by child **can** eat (be specific) _____

When my child has a reaction to eating this food you will see these symptoms _____

Medications necessary to treat my child's reaction to this food allergy are _____