Food Allergy Action Plan

Name of Student_____ D.O.B._____

Allergy to_____

Asthmatic Yes* No *Higher risk for severe reaction

Treatment

Symptoms: Circle those that apply.	**Give Checked Medication**
• Food allergen has been ingested but no symptoms	o Epinephrine o Antihistamine
• Mouth: itching, tingling, or swelling of lips, tongue, and/or mouth	o Epinephrine o Antihistamine
• Skin: hives, itchy rash, swelling of the face and/or extremities	o Epinephrine o Antihistamine
• Gut: nausea, abdominal cramps, vomiting, and/or diarrhea	o Epinephrine o Antihistamine
• Throat:† tightening of throat, hoarseness, and/or hacking cough	o Epinephrine o Antihistamine
• Lung:† shortness of breathe, repetitive coughing, and/or wheezing	o Epinephrine o Antihistamine
• Heart:† weak or thready pulse, low blood pressure, fainting, pale, and/or blueness	o Epinephrine o Antihistamine
• Other:† _____	o Epinephrine o Antihistamine
• If reaction is progressing (several of the above areas affected), give:_____	o Epinephrine o Antihistamine

† Potentially life-threatening.

Dosage

Epinephrine: Inject intramuscularly (circle one) Epipen® Epipen Jr.® Twinject ™ 0.3mg Twinject ™0.15mg

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

Signature of Parent or Guardian_____ Date_____

Signature of Doctor _____ Date_____