Food Allergy Action Plan

Eugene Pediatric ASSOCIATES
541-HUG-KIDS OR 541-484-5437

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 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, vomitting, diarrhea	❑ Epinephrine	❑ Antihistamine
• Throat†	Tightening of throat, hoarseness, hacking cough	❑ Epinephrine	❑ Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	❑ Epinephrine	❑ Antihistamine
• Heart†	Weak or 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

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

DOSAGE

Epinephrine: inject intramuscularly _____
medication/dosage

Antihistamine: give orally _____
medication/dosage

Other: give _____
medication/dosage

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.

2. Dr. _____ Phone Number: _____

3. Parent _____ Phone Number: _____

4. 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!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature (Required) _____ Date _____