

DATE: _____

Food Allergy Action Plan



Place
Child's
Picture
Here

ALLERGY TO: _____

Student's Name: _____ D.O.B.: _____ Teacher: _____

Asthmatic Yes* No *High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems: Symptoms:

- MOUTH itching & swelling of the lips, tongue, or mouth
- THROAT* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN hives, itchy rash, and/or swelling about the face or extremities
- GUT nausea, abdominal cramps, vomiting, and/or diarrhea
- LUNG* shortness of breath, repetitive coughing, and/or wheezing
- HEART* "thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION FOR MINOR REACTION ◆

1. If **only symptom(s)** are: _____, give _____
medication/dose/route

Then call:

2. Mother _____, Father _____, or emergency contacts.
3. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. If **ingestion is suspected and/or symptom(s)** are: _____,
give _____ IMMEDIATELY!
medication/dose/route

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother _____, Father _____, or emergency contacts.
4. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature _____ Date _____ Doctor's Signature _____ Date _____