MOUNT PISGAH
CHRISTIAN SCHOOL

Action Plan: Food Allergy

Student Name: ________________________________ **DOB:** ____________

ALLERGY TO: ____

STEP 1: TREATMENT

Symptoms Give Checked Medication
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 quickly change. *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

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. ________________________ at ________________________ 3.

Emergency Contacts:

Name/Relationship	Phone Number Contact #1	Phone Number Contact #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)

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