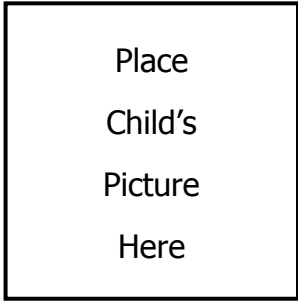


# FOOD ALLERGY ACTION PLAN



Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Level \_\_\_\_\_ Teacher \_\_\_\_\_

ALLERGIC TO: \_\_\_\_\_

Asthmatic \_\_\_\_Yes\* \_\_\_\_ No (\* higher risk for severe reaction)

## STEP 1: TREATMENT

Symptoms - give Checked Medication:

If a food allergen has been ingested, but no symptoms:

EpiPen  Antihistamine

Mouth itching, tingling or swelling of lips, tongue mouth:

EpiPen  Antihistamine

Skin Hives, itchy rash, swelling of the face or extremities:

EpiPen  Antihistamine

Gut Nausea, abdominal cramps, vomiting, diarrhea:

EpiPen  Antihistamine

Throat = tightening of throat, hoarseness, hacking cough:

EpiPen  Antihistamine

Lung = shortness of breath, repetitive coughing, wheezing:

EpiPen  Antihistamine

Heart = thready pulse, low blood pressure, fainting, pale, blueness:

EpiPen  Antihistamine

Other = \_\_\_\_\_

EpiPen  Antihistamine

If reaction is progressing (several of the above areas affected) give:

EpiPen  Antihistamine

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

## DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen OR EpiPen Jr.

Antihistamine: give \_\_\_\_\_medication/dose/route

Other: give \_\_\_\_\_medication/dose/route

**STEP TWO: 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(s)

A.

\_\_\_\_\_  
\_\_\_\_\_

B.

\_\_\_\_\_  
\_\_\_\_\_

C.

\_\_\_\_\_  
\_\_\_\_\_

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

The student is both capable and responsible for self administering the EpiPen

Yes     No

I give my permission to have Faith Formation staff members and those listed below, administer an Epi Pen prescribed by Dr. \_\_\_\_\_ to my child.

IN ADDITION:

- 1) \_\_\_\_\_ Room \_\_\_\_\_
- 2) \_\_\_\_\_ Room \_\_\_\_\_
- 3) \_\_\_\_\_ Room \_\_\_\_\_

- I give permission to Our Lady of Grace Parish to share with appropriate personnel this information as deemed necessary for my child's health and safety.
- I release Our Lady of Grace Parish, its officers, directors, agents, employees, independent contractors, licensees and assignees from all claims that I now have or in the future may have, relating to the above.
- I am the parent or guardian of the minor named on page one, and I hereby consent to the foregoing on behalf of the minor and myself.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_