Food/Insect Allergy Action Plan

Student's Name: _____ Date of Birth: _____ 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, 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 change quickly. *Potentially life-threatening.

DOSAGE
Epinephrine: inject intramuscularly _____
Name of Medication

Antihistamine: _____
Medication / Dose / Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Step 2: Emergency Calls

1. Call 911 (EMS: _____). State than an allergic reaction has been treated, and additional epinephrine may be needed.
2. 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.

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

☐ I certify that this child has a medical history of allergy and has been trained in the use of epinephrine, and is judged by me to be:

_____ capable of carrying and self-administering the listed medication(s),

_____ **NOT** capable of carrying and self-administering the listed medication(s).

_____	_____	_____
Physician Name (PRINT)	Physician Signature	Date
_____	_____	_____
Parent Name (PRINT)	Parent Signature	Date

Reviewed by: _____ Date: _____

*Refer to 504 coordinator if appropriate

Revised: July 2023