Food Allergy Action Plan

STUDENT NAME: _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____

(circle all that appy)

MEDICATION LOCATED: On Student In Classroom w/Teacher School Office Child Care

Children attending SGCC may not carry medication in their pockets or backpacks due to child care state licensing regulations

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†	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 (**circle one**) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
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. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. *Dr:* Phone # :
3. *Parent:* Phone # :
4. Emergency contacts:

Name/Relationship Phone # :

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 _____ Date: _____
(Required)

Signing this form shall release St. Gabriel School, St. Gabriel Parish, St. Gabriel Child Care and staff members from any liability of any nature that might result from the administration of this medication to the student.