Food Allergy Action Plan

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 **911** (ask for advanced life support)
3. Parents (see above phone numbers)
4. Dr. (see above)

_____DO NOT HESITATE TO CALL RESCUE SQUAD!_____
_____

Parent signature _____Date___ Doctor's Signature_____Date_____