ALLERGY ACTION PLAN, sample

Name: _____Date of birth: _____

Allergy to: _____

Weight: _____lbs. Asthma: _____Yes (higher risk for a severe reaction) _____No

Extremely reactive to the following foods: _____

THEREFORE:

_____, if checked, give epinephrine auto-injector for ANY symptoms if the allergen was *likely* eaten or exposed to allergen.

_____, if checked, give epinephrine auto-injector immediately if the allergen was *definitely* eaten, even if no symptoms noted.

Any severe symptoms after suspected or known ingestion:
One or more of the following:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or *combination of symptoms* from different body areas:
Skin: Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut: Vomiting, crampy pain

PLAN

1. **INJECT EPINEPHRINE AUTO-INJECTOR IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications: *
   - Antihistamine
   - Inhaler (bronchodilator) if asthmatic

   *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE AUTO-INJECTOR

Mild symptoms only:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

PLAN

1. **GIVE ANTIHISTAMINE**
2. Stay with student: alert health care professionals and parent
3. IF symptoms progress (see above), USE EPINEPHRINE AUTO-INJECTOR
4. Begin monitoring

Medications/Doses

Epinephrine auto – injector (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with the student, alert healthcare professionals and the parent. **Tell rescue squad epinephrine auto-injector was given; request an ambulance with epinephrine.** Note time when epinephrine auto-injector was administered. A second dose of epinephrine auto - injector can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. **Treat student even if parents cannot be reached.**

_____ _____

Parent /Guardian Signature Date

_____ _____

Physician/Healthcare Provider Signature Date

Form and instruction must be signed by physician to be complete and the diocesan medication form is required for the student.

A food allergy response kit should contain at least **two doses** of epinephrine auto-injector, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

This is the responsibility of the teacher of the student to bring medication/administer medication if needed and to also bring emergency medical contact information.

Contacts

Call 911

Physician: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other emergency contacts

Name/relationship: _____ Phone: _____

Name /relationship: _____ Phone: _____

References: Allergy ready, https://www.allergyready.com/
FARE, https://www.smiths-medical.com/products/patient-monitoring