

Food Allergy Emergency Action Plan- 2017/2018

Student's Name: _____

D.O.B: _____ Grade: _____ Homeroom Teacher: _____

ALLERGY TO: _____

Does your child have a history of asthma? * Yes No *If yes, HIGH RISK for severe reaction

Signs/Symptoms of an Allergic Reaction

- MOUTH: Itching/swelling of the lips, tongue, &/or mouth
- *THROAT: Hoarseness, hacking cough, itching &/or sense of tightness in the throat
- SKIN: Hives, itchy rash, &/or swelling of the face/extremities
- ABDOMEN: Nausea, cramping, vomiting, &/or diarrhea
- *LUNG: Shortness of breath, repetitive coughing, &/or wheezing
- *HEART: Thready pulse, syncope or near-syncope

*All above signs/symptoms can potentially progress to a life-threatening situation. The severity of symptoms can quickly change.

✦ ACTION FOR MINOR REACTION ✦

1. If the only symptom is _____,
give _____ (medication/dose/route).
2. Call Mom: _____
Dad: _____
Emergency Contact: _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

✦ ACTION FOR MAJOR REACTION ✦

1. If ingestion is suspected &/or symptoms are _____,
Give EpiPen/EpiPen Jr. **IMMEDIATELY!!**
Then call:
2. 911
3. Mom: _____
Dad: _____
Emergency Contact: _____

IF EPINEPRINE IS ADMINISTERED, YOU MUST CALL 911!!

Parent's Signature: _____ Date: _____

EMERGENCY CONTACTS:	TRAINED STAFF MEMBERS:
1. Name/Relationship:	1. Name: Keri Faust, RN
Phone Number:	Room #: Clinic- 156
2. Name/Relationship:	2. Name:
Phone Number:	Room #:
3. Name/Relationship:	3. Name:
Phone Number:	Room #:

