# Food Allergy Action Plan
## Collingdale Nazarene Christian School (CNCS)

**Student's Name:**_____ **D.O.B:**_____ **Teacher:**_____

**Place Child's Picture Here**

**ALLERGY TO:**_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

| Symptoms: | | Give Checked Medication**: (**To be determined by physical authorizing treatment) |
|---|---|---|
| ■ | If 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 quickly change. †Potentially life-threatening.

### DOSAGE

**Epinephrine:** inject intramuscularly (circle or) 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 (or Rescue Squad:_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number:_____

3. Parents _____ Phone Number(s):_____

4. Emergency Contacts:
Name/Relationship

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 Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)