

FOOD / BEE ALLERGY ACTION PLAN

Student's name _____ D.O.B. _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

SYMPTOMS:

Give Checked Medications**:

** to be determined by physician authorizing treatment

<input type="checkbox"/> If a food allergen has been ingested, but no symptoms:	<input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Mouth Itching, tingling	<input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
Swelling of lips, tongue, mouth	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Skin Localized hives, itchy rash	<input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
Generalized hives, swelling of the face or extremities	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Gut Nausea, abdominal cramps, vomiting, diarrhea	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Throat † Tightening of throat, hoarseness, hacking cough	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Lung † Shortness of breath, repetitive coughing, wheezing	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Heart † Thready pulse, low blood pressure, fainting, pale, bluenes	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Other † _____	<input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> If reaction is progressing (several of the above areas affected) †	** <input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine

† Potentially life threatening The severity of the symptoms can quickly change.

** Always give Epinephrine FIRST where indicated

The Asthma and Allergy Foundation recommends each child have a twin pack.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen®0.3mg EpiPen Jr.® 0.15mg Twinject™ 0.3mg Twinject™ 0.15mg
(see reverse side for instructions)

May repeat Epinephrine _____ minutes after 1st dose if symptoms continue to progress.

First dose was administered at _____am/pm.

Antihistamine: give Benadryl (Diphenhydramin) } } may repeat every 4 hours as needed

Liquid	<input type="checkbox"/> 25 mg (2 tsp)	<input type="checkbox"/> 50 mg (4 tsp)
Chewable Tablet	<input type="checkbox"/> 25 mg (2 tablets)	<input type="checkbox"/> 50 mg (4 tablets)
Oral tablet/Film	<input type="checkbox"/> 25 mg	<input type="checkbox"/> 50 mg

Other: give _____ medication/dose/route

Doctor's Signature _____ Date _____

◆ STEP 2: EMERGENCY CALLS ◆

1. **Call 9 1 1.** State that an allergic reaction has been treated, and an additional epinephrine may be needed.

2. Dr. _____ telephone # _____

3. Emergency contacts:

Name/relationship	Phone Number(s)
a. _____	1.) _____ 2.) _____
b. _____	1.) _____ 2.) _____
c. _____	1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY !

I give consent to trained personnel to administer the epinephrine and antihistamine as indicated above.

Parent/ Guardian Signature _____ Date _____