Food Allergy Action Plan

Place Child's Picture Here

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 (ask for advanced life support)
3. Mother_____, Father _____, or emergency contacts.
4. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature_____Date_____ Doctor's Signature_____ Date_____