

KINGSTON INTERMEDIATE SCHOOL
SILVER LAKE REGIONAL SCHOOL DISTRICT
FOOD ALLERGY ACTION PLAN

Place
Child's
Picture
Here

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

ALLERGY TO: _____

Asthmatic YES* NO *Higher risk for severe reaction

◆ **STEP 1: TREATMENT** ◆

Symptoms:

Give Checked Medication:**

To be determined by physician authorizing treatment

- If a food allergen has been ingested, but *no symptoms*: EpiPen Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth EpiPen Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities EpiPen Antihistamine
- Gut Nausea, abdominal cramps, vomiting, diarrhea EpiPen Antihistamine
- Throat† Tightening of throat, hoarseness, hacking cough EpiPen Antihistamine
- Lung† Shortness of breath, repetitive coughing, wheezing EpiPen Antihistamine
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness EpiPen Antihistamine
- Other† _____ EpiPen Antihistamine
- If reaction is progressing (several of the above areas affected), give EpiPen Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

◆ **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. _____ at _____

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!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)