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:

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

Give Checked Medication:**
**(To be determined by physician authorizing treatment)

☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) 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: _____ at_____

3. Parents_____ Phone Number(s)_____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
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)

TRAINED STAFF MEMBERS

1. _____ Room _____

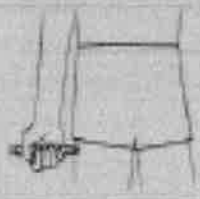
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.

- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

"Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.

RELEASE FOR DISPENSING OF MEDICATION

We, the undersigned parent and/or guardian of:

_____ _____ Born ____/____/____
(Student's Name) (Grade/Room #) Mo Day Yr

do hereby sign and execute this release on behalf of us and on behalf of our minor son/daughter/ward.

NAME OF MEDICATION: _____

DOSE: _____

TIME TO BE GIVEN: _____

DURATION: _____

ATTACH DOCTOR'S NOTE REGARDING ADMINISTRATION OF MEDICATION

☐ **Check here, and attach emergency care plan, if this release is for a metered dose asthma inhaler or epinephrine auto-injector, which the student will possess and use at his/her own discretion in school or at school activities. The physician and parents/guardian signature below apply to the inhaler or epinephrine auto-injector possession and use by students as permitted in Public Act 10 – Revised School Code.**

_____ _____ _____
(Doctor's Signature) (Please Print Name) (Date)

___(____)_____
(Phone Number)

We hereby waive any liability whatever to the school or the Archdiocese of Detroit or any of its personnel, that might occur as the result of giving said medication in the indicated dosage at the time requested to our minor son/daughter/ward.

PARENT/GUARDIAN _____
(Signature)

_____
(Print Name)

DATE _____

Aug. 2014