**Food / Insect Allergy Action Plan**

Student’s Name: Date of Birth: 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: | | * 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 |

# DOSAGE

## The severity of symptoms can change quickly. \*Potentially life-threatening.

**Epinephrine**: inject intramuscularly

Name of Medication

**Antihistamine**:

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 than an allergic reaction has been treated, and additional epinephrine may be needed.

2. 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.

I give Hall County School employees permission to contact my child’s health care provider and/or pharmacy to acquire medical information concerning my child’s diagnosis, medication, and other treatment(s) required.

I certify that this child has a medical history of allergy and has been trained in the use of epinephrine, and is judged by me to be:

capable of carrying and self-administering the listed medication(s).\*\*Complete a Hall County Permission to Self Carry form

*NOT capable of carrying and self-administering the listed medication(s)\*\*Complete a Hall County Parent Medication Permission form*

*Parent/Guardian Signature Date: \_*

*Physician’s Signature (required)*

*Phone #: Date:*

*Reviewed by School Nurse: Date:*

\*Refer to 504 coordinator if appropriate 8/17