Food/Insect Allergy Action Plan
Health Services

Student Name: _____ Student #: _____ Grade: _____
DOB: _____ School: _____ Date Form Completed: _____
Homeroom 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

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

DOSAGE:

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)
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**

Revised 11/2022