

**ALLERGY ACTION PLAN, sample**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: \_\_\_\_\_ Yes (higher risk for a severe reaction) \_\_\_\_\_ No

Extremely reactive to the following foods: \_\_\_\_\_

**THEREFORE:**

\_\_\_\_\_, if checked, give epinephrine auto-injector for ANY symptoms if the allergen was *likely* eaten or exposed to allergen.

\_\_\_\_\_, if checked, give epinephrine auto-injector immediately if the allergen was *definitely* eaten, even if no symptoms noted.

**Any severe symptoms after suspected or known ingestion:**

*One or more of the following:*

**Lung:** Short of breath, wheeze, repetitive cough

**Heart:** Pale, blue, faint, weak pulse, dizzy, confused

**Throat:** Tight, hoarse, trouble breathing/swallowing

**Mouth:** Obstructive swelling (tongue and/or lips)

**Skin:** Many hives over body

Or *combination of symptoms* from different body areas:

**Skin:** Hives, itchy rashes, swelling (e.g., eyes, lips)

**Gut:** Vomiting, crampy pain

**PLAN**

1. **INJECT EPINEPHRINE AUTO-INJECTOR IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications: \*
  - Antihistamine
  - Inhaler (bronchodilator) if asthmatic

\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE AUTO-INJECTOR

**Mild symptoms only:**

Mouth: Itchy mouth

Skin: A few hives around mouth/face, mild itch

GUT: Mild nausea/discomfort

**PLAN**

1. **GIVE ANTIHISTAMINE**
2. Stay with student: alert health care professionals and parent
3. IF symptoms progress (see above), USE EPINEPHRINE AUTO-INJECTOR
4. Begin monitoring

**Medications/Doses**

Epinephrine auto – injector (brand and dose): \_\_\_\_\_

Antihistamine (brand and dose): \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

**Monitoring**

Stay with the student, alert healthcare professionals and the parent. **Tell rescue squad epinephrine auto-injector was given; request an ambulance with epinephrine.** Note time when epinephrine auto-injector was administered. A second dose of epinephrine auto - injector can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. **Treat student even if parents cannot be reached.**

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Healthcare Provider Signature

\_\_\_\_\_  
Date

**Form and instruction must be signed by physician to be complete and the diocesan medication form is required for the student.**

A food allergy response kit should contain at least **two doses** of epinephrine auto-injector, other medications as noted by the student’s physician, and a copy of this Food Allergy Action Plan.

**A kit must accompany the student if he/she is off school grounds (i.e., field trip).**

This is the responsibility of the teacher of the student to bring medication/administer medication if needed and to also bring emergency medical contact information.

**Contacts**

**Call 911**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

**Other emergency contacts**

Name/relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name /relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

References: Allergy ready, <https://www.allergyready.com/>  
FARE, <https://www.smiths-medical.com/products/patient-monitoring>