PLEASE COMPLETE THIS FORM ONLY IF YOUR CHILD HAS ANY ALLERGY

FOOD ALLERGY ACTION PLAN

Student's Name:__________________________________D.O.B.______________Camp:______________________

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 quickly change.
†Potentially life-threatening.

Epinephrine: inject intramuscularly (circle one) Epi Pen ® EpiPen ® Jr. Twinject™ 0.3mg Twinject™ 0.15mg

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. ____________________________________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**______________________________________
(Required)