YONKERS PUBLIC SCHOOLS

Food Allergy Action Plan

Student's Name:____ **D.O.B:**________________

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.

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

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______________

Doctor's Signature____ Date______________
(Required)