Food Allergy Action Plan 2021 – 2022

BETH TORAH SCHECK FAMILY RELIGIOUS SCHOOL

Student's Name: _____D.O.B: _____ Teacher: _____

Allergy To:

_____

Asthmatic: Yes ☐ No ☐ (higher risk for severe reaction if Yes)

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 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

Epinephrine: inject IM (circle one): EpiPen®0.3 mg EpiPen® Jr. 0.15mg Twinject 0.3 mg Twinject 0.15 mg
Auvi-Q 0.3mg Auvi-Q 0.15mg

Antihistamine: give_____
Medication/dose/route

Other: give_____
Medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____ phone #:_____
3. Emergency contacts:

Name/Relationship	Phone Number
a. _____	_____
b. _____	_____

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**)

A TIME LIKE this

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