School Year

20___-20___

Jackson-Madison County School System
Food Allergy Action Plan

Place Child's Picture Here

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

Allergy to: _____ Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

*** STEP 1: TREATMENT ***

Symptoms:	**Give Checked Medication**:**
• 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† Weak or thread 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

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

Epinephrine: inject intramuscularly (circle one)

EpiPen® EpiPen®Jr. Twinject®0.3mg Twinject®0.15mg Adrenaclick™0.3mg Adrenaclick™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. Medical Provider _____ Phone Number_____
3. Parent _____ Phone Number_____
4. Emergency contacts:
   A. Name/Relationship _____ Phone Number _____

   B. Name/ Relationship _____ Phone Number _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/ Guardian's Signature _____Date_____

Medical Provider's Signature _____ Date _____

(REQUIRED)

REVISED 3/2018