◆ FOOD ALLERGY ACTION PLAN ◆

Site: _____

Child'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* :	☐ None	☐ EpiPen	☐ Antihistamine
▪ Mouth	itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat ★	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung ★	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart ★	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other ★	_____	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

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

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen (.3mg) EpiPen Jr. (.15mg)

Antihistamine: _____
medication dose route

Other: _____
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. Call QCARE administration at (617) 773-3299. They can help you reach emergency contacts.

EVEN IF PARENT/GUARIDAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR SEEK MEDICAL CARE!

Parent/Guardian Signature _____ Date _____

Physician's Signature _____ Date _____