St. Therese Early Education Center

Child Food Allergy Action Plan

Child's Name: _____Class: _____

Allergy To:_____

Asthmatic: _____Yes _____No *Higher risk for severe reaction

Step 1 - Treatment

Symptoms **+Potentially life-threatening. The severity of symptoms can quickly change**	To be determined by physician authorizing treatment (**Check to administer**) Must be in original container with prescription label	Antihistamine must be listed on Medication Consent form and signed by Physician
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 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: (circle one) EpiPen EpiPen Jr Twinject 0.3mg Twinject 0.15mg

Antihistamine: give_____
medication/dose/route

Other: give_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

Step 2: Call for Emergency Assistance

1. Call 911 and state that an allergic reaction has been treated, and additional assistance is needed
2. Call Emergency Contacts located in ProCare or Emergency Binder at front desk.

Parent/Guardian Signature_____ Date_____
By signing this form, I agree to allow the center to post my child's food allergy information.

Reviewed by Center Administration_____ Date_____