FOOD ALLERGY / INSECT ALLERGY ACTION PLAN

NAME:_____ D.O.B:_____

ALLERGY TO:_____

Asthmatic: ☐ YES* ☐ NO *Higher risk for severe reaction

♦ STEP 1: TREATMENT♦

SYMPTOMS:	**GIVE CHECKED MEDICATION(S)**:** **** (TO BE DETERMINED BY PHYSICIAN AUTHORIZING TREATMENT)**
• If food allergen has been ingested, or child has been stung, *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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3mg Twinject® 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. Dr._____ Phone Number:_____
3. Parent_____ Phone Number:_____
4. Emergency Contacts: (Name / Relationship) Phone Number(s)
   a._____ 1)_____ 2)_____
   b._____ 1)_____ 2)_____

EVEN IF PARENT OR GUARDIAN CANNOT BE REACHED DO NOT HESITATE, TO MEDICATE OR HAVE CHILD TRANSPORTED TO A MEDICAL FACILITY

PARENT / GUARDIAN'S SIGNATURE_____ **DATE:**_____

DOCTOR'S SIGNATURE_____ **DATE:**_____