

FOOD ALLERGY ACTION PLAN

Child's Photograph

NAME: _____ DOB: ____/____/____

ALLERGY TO: _____

Asthma: Yes (higher risk for a severe reaction) No.

Weight ____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/ swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- CALL 911
- Begin Monitoring (see below)
- Additional medications:
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.
When in doubt, use epinephrine. Symptoms can rapidly become more severe

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: mild nausea/discomfort

GIVE ANTIHISTAMINE

-Stay with child, alert health care professionals and parent
IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

- If checked, give epinephrine for ANY symptoms if the allergen was likely eaten (extremely reactive).
- If checked, give epinephrine before symptoms if the allergen was definitely eaten (extremely reactive)

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

OTHER (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached. See back/attached for auto-injection technique.

For insect sting allergy, inject epinephrine for any symptoms other than localized swelling at sting site

CONTACTS: CALL 911 (Rescue squad: (____)_____) Doctor: _____ Phone: (____)_____-_____

Parent/Guardian: _____ Phone: (____)_____

OTHER EMERGENCY CONTACT: NAME/Relationship _____ Phone: (____)_____-_____

NAME/Relationship _____ Phone: (____)_____-_____

PARENT/GUARDIAN SIGNATURE

DATE

PHYSICIAN/HEALTHCARE PROVIDER SIGNATURE

DATE