

Food Allergy Action Plan

129 Fulton St.
 60 Catherine St.
 77 Market St.
 253 South St.


Child's Name:	Date of Birth	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian:	Cell:	Email:

Extremely reactive to the following allergens:


Weight:

Asthma: No YES (higher risk for a severe reaction)


Severe Symptoms




Lung
Shortness of breath, wheezing, repetitive cough




Heart
Pale or bluish skin, faintness, weak pulse, dizziness




Throat
Tight or hoarse throat, trouble breathing or swallowing




Mouth
Significant swelling of the tongue or lips




Skin
Many hives over body, widespread redness



Gut
Repetitive vomiting, severe diarrhea




Other
Feeling something bad is about to happen, anxiety, confusion




Anaphylaxis Action Plan

- If prescribed, administer epinephrine as ordered (Epi-pen Jr., Auvi-Q, Twinject).
- Call 911 immediately!** 911 must be called whenever an epinephrine auto-injector is administered.
- Advise 911 that child is having a severe allergic reaction and the Epinephrine is being administered.
- A CPR-trained adult must remain with child at all times, at the location where symptoms began until EMS arrives. Begin CPR if necessary.
- Alert Emergency contacts.
- Give used epinephrine auto-injector to EMS along with a copy of the Food Allergy Action Plan.


Mild Symptoms




Nose
Itchy or running nose, sneezing



Mouth
Itchy mouth



Skin
A few hives, mild itch



Gut
Mild nausea or discomfort

For mild symptoms

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the child and call emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

EMERGENCY CONTACT		
Name of Emergency Contact	Relationship to child	Phone Number

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To be completed by Health Care Provider with the Parent/Guardian:

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

List all of the food items or ingredients that this child is allergic to, intolerant of, or needs to avoid for a **medical condition** below. For each food item/ingredient listed below, please list possible substitutes, check if symptoms are severe or mild and what the symptoms are, and if medication is required.

Date Allergy was diagnosed/ Tested:		
Food/ingredient Allergy to: <input type="checkbox"/> Avoid completely List food substitutions:	Child's symptoms are: <input type="checkbox"/> Life Threatening/Severe <input type="checkbox"/> Mild Check all that apply: <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Itching <input type="checkbox"/> Stomach pain <input type="checkbox"/> Wheezing <input type="checkbox"/> Swelling <input type="checkbox"/> Gas <input type="checkbox"/> Dizziness <input type="checkbox"/> Redness <input type="checkbox"/> Bloating <input type="checkbox"/> Hives <input type="checkbox"/> Nausea <input type="checkbox"/> Other: <input type="checkbox"/> Rash <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea	Is medication required if the food is consumed? <input type="checkbox"/> No <input type="checkbox"/> Yes - specify:
Food/ingredient Allergy to: <input type="checkbox"/> Avoid completely List food substitutions:	Child's symptoms are: <input type="checkbox"/> Life Threatening/Severe <input type="checkbox"/> Mild Check all that apply: <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Itching <input type="checkbox"/> Stomach pain <input type="checkbox"/> Wheezing <input type="checkbox"/> Swelling <input type="checkbox"/> Gas <input type="checkbox"/> Dizziness <input type="checkbox"/> Redness <input type="checkbox"/> Bloating <input type="checkbox"/> Hives <input type="checkbox"/> Nausea <input type="checkbox"/> Other: <input type="checkbox"/> Rash <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea	Is medication required if the food is consumed? <input type="checkbox"/> No <input type="checkbox"/> Yes - specify:
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Parent/Guardian Authorization Signature	Physician's Authorization Signature
Date	Date and Stamp