Student Food Allergy Emergency Action Plan

This plan should be completed by the student's physician and parent/guardian. Keep a copy in the school clinic and provide copies to the student's teachers.

1. Student Information

Student Full Name:

Date of Birth: Grade/Homeroom:

Teacher: School Year:

Asthma: Yes / No *(Note: High risk for severe reaction if student has asthma)*

2. Allergens

This student is highly allergic to the following food(s):

Describe past reactions:

3. Emergency Contacts

Parent/Guardian 1 Name: Relationship:

Phone Number 1: Phone Number 2:

Parent/Guardian 2 Name: Relationship:

Phone Number 1: Phone Number 2:

Primary Care Physician: Phone Number:

Allergist: Phone Number:

4. Action Plan for Symptoms

Mild Symptoms

- Mouth: Itchy mouth, minor tingling
- Skin: A few hives, mild itch, mild swelling around mouth/face
- Gut: Mild nausea, stomach discomfort

Action for Mild Symptoms: e.g., Give Antihistamine, monitor closely

Medication/Dosage (Mild):

Severe Symptoms

- Lung: Shortness of breath, wheezing, repetitive cough
- Heart: Pale, blue color, weak pulse, dizziness, passing out
- Throat: Tightness, hoarse voice, trouble breathing/swallowing
- Mouth: Significant swelling of the tongue and/or lips
- Skin: Many hives over body, widespread redness
- Gut: Repetitive vomiting or severe diarrhea
- Other: Feeling of impending doom, confusion, anxiety

Action for Severe Symptoms: Inject Epinephrine Immediately and Call 911!

Epinephrine Brand/Device: e.g., EpiPen, Auvi-Q

Epinephrine Dosage: e.g., 0.15 mg, 0.3 mg

Antihistamine (if any to be given after Epinephrine):

5. Authorization and Signatures

I hereby authorize the school staff to administer the prescribed medications and follow the protocol outlined in this emergency plan.

Physician Name: Physician Signature: Date:

Parent/Guardian Name: Parent/Guardian Signature: Date: