If your child needs an epi pen, we must have it on the 1stday of school.

Great Beginnings Christian Preschool & Kindergarten

Food Allergy Action Plan

(Must have) Child's Picture Here

Student's Name: _____ D.O.B. _____ Teacher: _____

ALLERGY TO: _____

Asthmatic ☐ Yes* ☐ No *Higher risk for severe reaction Weight: _____lbs _____ kg

Does this allergy include: (**circle ALL that apply**) Ingestion Touching the allergen Air-born allergen particles Insect bite/sting

Has child ever had an epinephrine (epi-pen) injection before? ☐ Yes ☐ No

♦ STEP 1: TREATMENT ♦

Symptoms:	**Give Checked Medication**** (**to be determined by physician authorizing treatment)
• If a food allergen has been ingested, but NO SYMPTOMS	☐ Epinephrine ☐ Antihistamine
• Mouth Itching, tingling, or swelling of lips, mouth, tongue	☐ Epinephrine ☐ Antihistamine
• Skin Hives, itchy rash, swelling of face or extremities	☐ Epinephrine ☐ Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• Throat† Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• Lungs† Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• Heart† Thready pulse, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Other†: _____	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several areas may be affected) give:	☐ Epinephrine ☐ Antihistamine

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

_____ (Parent initials needed) - Epinephrine pens and antihistamines are to be provided by the parents and will be stored in marked medical boxes, with a copy of this plan.

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

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed. This call will be made before calling parents unless noted here.

2. Dr. _____ Dr.s phone #: _____

3. **Emergency contacts:** (use additional paper if needed)

Name/Relationship (**please include parent as one**)	Phone Numbers (s)	
a_____	1. _____	2. _____
b. _____	1. _____	2. _____
c. _____	1. _____	2. _____

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)