Phone: 704-237-5333 Fax: 704-237-5398

FOOD ALLERGY ACTION PLAN

This record is to be completed by parents/guardians in consultation with their child's physician. Please check the appropriate box and print your answers clearly in the blank spaces where indicated. The information on this Plan is confidential. All staff that care for your child will have access to this information. The school will only disclose this information to others with your consent. Please contact the school at any time if you need to update this Plan or you have any questions regarding the management of severe food allergies at school. It is the responsibility of the parent/guardian to assure the Food Allergy Action Plan is in place for their child and the school is provided with adequate medication as stated in the Guidelines for Management of Students with Severe Allergies in the Pine Lake Preparatory Handbook.

Student's Name _____D.O.B. _____

Grade _____Teacher _____

ALLERGIC TO: _____

Asthmatic_ [ ] Yes* [ ] No *Higher risk for severe reaction

STEP ONE: RECOMMENDED TREATMENT

Symptoms:		**Give Checked Medication**:**	
• If a food allergen has been ingested, but *no symptoms*		[ ] EpiPen	[ ] Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	[ ] EpiPen	[ ] Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	[ ] EpiPen	[ ] Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	[ ] EpiPen	[ ] Antihistamine
• Throat+	Tightening of throat, hoarseness, hacking cough	[ ] EpiPen	[ ] Antihistamine
• Lung+	Shortness of breath, repetitive coughing, wheezing	[ ] EpiPen	[ ] Antihistamine
• Heart+	Weak/thread pulse, low blood pressure, fainting, pallor	[ ] EpiPen	[ ] Antihistamine
• Other+	_____	[ ] EpiPen	[ ] Antihistamine
• If reaction is progressing (several of above areas affected), give		[ ] EpiPen	[ ] Antihistamine

The severity of symptoms can change quickly + Potentially Life-threatening.

Dosage:

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr. (see attached for instruction)

Antihistamine (Medication/Dose/Route/Frequency): Give_____

Other (Medication/Dose/Route/Frequency): Give_____

STEP TWO: EMERGENCY CALLS

Nurse Ext: #5333/ cell # 704-237-5333

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at phone # _____
3. Emergency Contacts:

Name/Relationship:	Phone Number(s)	
a. _____	1) _____	2) _____
b. _____	1) _____	2) _____
c. _____	1) _____	2) _____

IN THE EVENT THAT A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Physician's Signature (required)_____ Date _____