



Visitation School

Health Office

Food Allergy Action Plan

Student's Name: _____ Date of Birth: _____



◆ Step 1: TREATMENT ◆

(Step 1 is to be completed by your child's physician)

Asthmatic: Yes* No *Higher risk for severe reaction

ALLERGIC TO: _____

Give Checked Medication

(to be determined by physician authorizing treatment)

- | | | |
|---|---------------------------------|--|
| If child has been in contact with a food allergen (touch, smell): | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| If child has ingested a food allergen, but no symptoms are apparent: | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Mouth Itching, tingling, or swelling of the lips, tongue, mouth | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Throat* Tightening of the throat, hoarseness, hacking cough | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Lung* Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Heart* Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| Other* _____ | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| If reaction is progressing (several of the above areas are affected), give: | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change.

* Potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly (circle one): EpiPen EpiPen Jr.

Antihistamine: give _____ medication / dose / route

Other: give _____ medication / dose / route

Licensed Prescriber's Signature Date (_____) Phone Number

◆ Step 2: EMERGENCY CALLS ◆

- Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
- Call Dr. _____ at (_____) _____
name phone number
- Call emergency contacts:

Name	Relation	Phone Number #1	Phone Number #2

***** EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY! *****

Parent/Guardian Signature Date (_____) Phone Number



Visitation School

Health Office

EpiPen Form

Visitation requires all students, who are prescribed an Epi-Pen by their physician, to supply the Visitation Health Office with a back- up Epi-Pen. This Epi-Pen is in addition to the Epi-Pen that they must carry with them throughout the school day.

Student Name: _____ Date of Birth: _____ Grade : _____

Please indicate specifically how you would like us to administer the EpiPen
(Form to be completed by your child's physician.)

The EpiPen is to be used after exposure to the following allergens:

Administer the EpiPen as follows (**check one**):

- Immediately after exposure to the above listed allergens.
- Only if the following symptoms are exhibited:

Whenever an EpiPen is administered, 911 is called immediately. If you have any additional instructions, please list them:

MD/NP/PA Signature	Date	(_____)_____ Phone Number
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