Food Allergy Action Plan

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

Parent/guardian Name _____ Cell Phone # _____

ALLERGY TO:_____

Asthmatic _____Yes* _____No *Higher risk for severe reaction
The severity of symptoms can quickly change. Potentially life-threatening.

STEP 1: TREATMENT --Symptoms: Administer EpiPen :

* If a food allergen has been ingested, but no symptoms
* Mouth Itching, tingling, or swelling of lips, tongue, mouth
* Skin Hives, itchy rash, swelling of the face or extremities
* Gut Nausea, abdominal cramps, vomiting, diarrhea
* Throat = Tightening of throat, hoarseness, hacking cough
* Lung = Shortness of breath, repetitive coughing, wheezing
* Heart = Thready pulse, low blood pressure, fainting, pale, blueness
* Other = _____
* If reaction is progressing (several of the above areas affected)

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STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____) .
State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr._____ at (_____)
3. Emergency contacts: Name/Relationship Phone Number(s)

_____

_____

_____

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

The student is both capable and responsible for self - administering the EpiPen
□ Yes □ NO

- I give my permission to St Joseph Church, to share with appropriate personnel this information as deemed necessary for my child's health and safety.
- I release St Joseph Church, its officers, directors, agents, employees, independent contractors, licensees and assignees from all claims that I now have or in the future may have, relating to the above.
- I am the parent or guardian of the minor(s) named below, and I hereby consent to the foregoing on behalf of the minor(s) and myself.

Signature of Parent / Guardian Signature_____ Date: _____

Doctor's Signature _____ Date: _____