MERIWETHER COUNTY SCHOOL SYSTEM
Food Allergy/Allergy Action Plan

Student's Name: _____ D.O.B._____
ALLERGY TO: _____
_____
TYPICAL REACTION _____

Asthmatic No _ Yes _ * *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: Give Recommended Medications**: ** medication
_ 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 _____
_ Nausea, abdominal cramps, vomiting, diarrhea _____
_ Throat **+** Tightening of throat, hoarseness, hacking cough _____
_ Lung **+** Shortness of breath, repetitive coughing, wheezing _____
_ Heart **+** Weak or thready pulse, low blood pressure, fainting, pale, blueness _____
_ If reaction is progressing (several of the above areas affected), give: _____
+Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE:
Epinephrine: Inject intramuscularly
(***PHYSICIANS PLEASE*** circle one if epinephrine is to be used)
EpiPen EpiPen Jr. Twinject® 0.3mg Twinject 0.15 mg
Adrenaclick 0.3mg Adrenaclick 0.15mg

Antihistamine: medication_____ dose/mg_____

IMPORTANT: Asthma inhalers or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

THE SCHOOL DOES NOT SUPPLY ANTIHISTAMINES OR EPINEPHRINE, SO YOU WILL NEED TO BRING THIS MEDICATION TO SCHOOL FOR YOUR CHILD.

REMEMBER TO TAKE EPI-PEN WITH YOU WHEN LEAVING THE BUILDING (e.g., field trip, evacuation, etc.)

STEP 2: EMERGENCY CALLS

1. **Call 911:** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Call Parent / Guardian or Emergency Contacts** listed on emergency forms.

Parent/Guardian Signature _____ Date _____
Doctor Signature _____ Date _____