APPS FOOD ALLERGY ACTION PLAN

Emergency Information for

PHOTO

_____ _____ ___
(Name)

Life-threatening allergies to:

- ☐ Peanuts
- ☐ All nuts from trees (pecans, walnuts, etc.)
- ☐ Milk
- ☐ Eggs
- ☐ Fish
- ☐ Shellfish
- ☐ Soy
- ☐ Wheat
- ☐ Sesame seed/sesame oils
- ☐ Other: (indicate) _____

The following action must be taken **immediately.**

STEP 1. Determine how to treat reaction promptly.

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, tongue, mouth	❒Epinephrine ❒Antihistamine
❒ Skin: Hives, itchy rash, swelling of the face or extremities	❒Epinephrine ❒Antihistamine
❒ Gut: Nausea, abdominal cramps, vomiting, diarrhea	❒Epinephrine ❒Antihistamine
❒ Throat:† Tightening of throat, hoarseness, hacking cough	❒Epinephrine ❒Antihistamine
❒ Lung:† Shortness of breath, repetitive coughing, wheezing	❒Epinephrine ❒Antihistamine
❒ Heart:† Weak or thready pulse, low blood pressure, fainting , pale, blueness	❒Epinephrine ❒Antihistamine
❒ Other† _____	❒Epinephrine ❒Antihistamine
❒ If reaction is progressing (several of the above areas affected), give:	❒Epinephrine ❒Antihistamine

†All of the above symptoms can progress to a life-threatening reaction.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine:
give_____
medication/dose/route

Other: give_____
medication/dose/route

STEP 2. Call 911 (or Rescue Squad _____) and request a paramedic with epinephrine. If epinephrine has already been given, state that more is required.

Emergency Contact Information:

Mother:	Emergency cell phone:	(_ _ _) _ _ _-_ _ _ _
	Home telephone:	(_ _ _) _ _ _-_ _ _ _
	Work telephone:	(_ _ _) _ _ _-_ _ _ _
Father:	Emergency cell phone:	(_ _ _) _ _ _-_ _ _ _
	Home telephone:	(_ _ _) _ _ _-_ _ _ _
	Work telephone:	(_ _ _) _ _ _-_ _ _ _
Other contact	(Name & Relationship)	
_____		(____) ____-_____
_____		(____)_____-_____

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

Parent/Guardian's Signature: _____
Date_____

Doctor's Signature _____
Date_____