Académie Lafayette

Food Allergy Action Plan

Student'sName:_____**D.O.B:**_____**Teacher:**_____

ALLERGY TO:_____
Asthmatic Yes* No *Higher risk for severe reaction

STEP 1: 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 = Thready pulse, low blood pressure, fainting, pale, blueness ☐ EpiPen ☐ Antihistamine
- Other = _____ ☐ EpiPen ☐ Antihistamine
- If reaction is progressing (several of the above areas affected), give ☐EpiPen ☐ 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

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)

a. _____ 1)_____ 2) _____
b._____ 1)_____ 2) _____
c. _____ 1)_____ 2) _____

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

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Academie Lafayette Nurse's Office
Oak Campus: Alexis Cook, RN – email: acook@academielafayette.org
Phone: 816-361-7735 Fax: 816-361-5788
Cherry Campus: Mary Ammatelli, RN – email: mammatelli@academielafayette.org
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