Springfield College
Child Development Center
715 Wilbraham Road, Springfield, MA 01109
(413) 788-2451

Food Allergy Action Plan

Place Child's Picture Here

Student's Name: _____

DOB: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

Step One: Treatment

Symptoms	**Give Checked Medication****	**to be determined by physician authorizing treatment
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 Two: Emergency Calls

1. Call 911 (or rescue squad: _____).
   State that an allergic reaction has been treated and that additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Call emergency contacts:

Name/Relationship	Phone Numbers	
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 the medical facility.

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature (required): _____ Date: _____