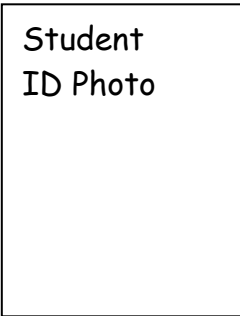


Food Allergy Action Plan- Physician Form



Name: _____ D.O.B _____ School Year/Grade _____

ALLERGY TO _____

Asthmatic (Higher risk for severe reaction) Yes _____ No _____

Symptoms:	Medication Needed As ordered by physician
If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Mouth Itching, tingling, or swelling lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Throat • Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Lung • Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Heart • Weak or thready pulse, low B/P, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Other •	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected) give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

- Potentially life-threatening. The severity of symptoms can quickly change.

ADMINISTER MEDICATION

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

Antihistamine: _____ (medication/dose/route)

Other: _____ (medication/dose/route)

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

IN CASE OF EMERGENCY

Call Ambulance: Sea Cliff: **671.0334** All other buildings: **742.3300**

State: an allergic reaction has been treated and follow-up care is needed.

Contact Parent _____ Phone Number _____

EVEN IF PARENT/GUARDIAN can't be reached, do not hesitate to medicate or take child to Medical Facility

PARENT/GUARDIAN SIGNATURE _____ Date _____

Doctor's. Name _____ Phone Number _____

DOCTORS SIGNATURE (required) _____ Date _____

STUDENT CARRIES OWN EPI-PEN YES _____ NO _____