Food Allergy & Anaphylaxis Action Plan

CATHOLIC SCHOOLS
Archdiocese of San Antonio
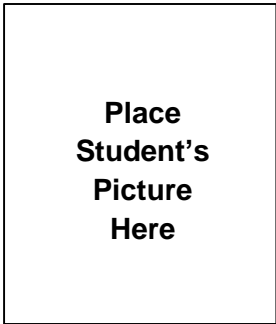
Name: _____ **D.O.B.:** ___ / ___ / ___

Allergy to: _____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:
SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

➡️

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
    -Antihistamine
    -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

➡️

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine: _____ Dose: _____

Antihistamine: _____ Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring
Stay with student; Monitor status continuously. Tell EMS epinephrine was given.

Does this student have <u>physician authorization</u> to <u>self-administer</u> this medication and to carry this medication on his/her person?   Yes ☐   **No** ☐

_____   _____
Parent/Guardian Signature   Date   **Physician/Health Care Provider Signature   Date**

_____
School Nurse/Health Coordinator Signature   Date

<u>Parent/Guardian must RETURN this form to the school nurse or health coordinator.</u>

<u>Emergency Contact Information:</u>

Parent/Guardian: _____   Phone: _____

Physician: _____   Phone: _____

<u>Other Emergency Contacts:</u>

Name/Relationship: _____   Phone: _____

Name Relationship: _____   Phone: _____