

West Islip Public Schools

Food Allergy/Anaphylaxis Action Plan

Medication Authorization

Place
picture
here

Student's Name: _____ DOB: _____ 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:

___ 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! 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

The severity of the symptoms can quickly change. ! Potentially life threatening.

DOSAGE

Epinephrine: give _____
medication/dose/route/frequency

Antihistamine: give _____
medication/dose/route/frequency

Other: give _____
medication/dose/route/frequency

Possible side effects or adverse reactions (if any): _____

Physician Signature _____ Date _____

Physician Information /**MUST HAVE MD STAMP**

STUDENT MAY SELF MEDICATE _____ **MD**

Parent/Guardian Signature _____ Date _____

STEP 2: EMERGENCY CALLS

Call 911-tell rescue squad epinephrine has been given (note time given); request ambulance with epinephrine.

Call Parent/Guardian: Name _____ phone: _____

Emergency contacts:

Name/Relationship: _____ phone: _____

_____ phone: _____