CATHOLIC SCHOOLS
— ARCHDIOCESE OF SAN ANTONIO —

Food Allergy & Anaphylaxis Action Plan

Place Student's Picture Here

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 physician authorization to self-administer 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**

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

Emergency Contact Information:

Parent/Guardian: _____ Phone: _____

Physician: _____ Phone: _____

Other Emergency Contacts:

Name/Relationship: _____ Phone: _____

Name Relationship: _____ Phone: _____