KEARNY PUBLIC SCHOOLS

FOOD ALLERGY ACTION PLAN

Student Name____ Date ________________

D/O/B ___________________________ Allergic to:_____________________________________

Documented Anaphylactic Reaction ____

Attached lab documentation of proof of allergy ____

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 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, faint, pale, blueness**	□ Epinephrine	□ Antihistamine
• Other____	□ Epinephrine	□ Antihistamine

Action for a MINOR reaction:
If symptoms are MINOR rash or MINOR itching – give Diphenhydramine _______ mg liquid/tablets

Action for a MAJOR reaction:
If symptoms progress, and/or person has cough, hoarseness of voice, tightness of throat, wheezing or shortness of breath, **give immediately**:

__________ Epi-pen or Twinject autoinjector 0.3 mg
__________ Epi-pen Jr. or Twinject autoinjector Jr. 0.15 mg
__________ Auvi-Q (epinephrine injection, USP) 0.15 mg
__________ Auvi-Q (epinephrine injection, USP) 0.30 mg

Then call Emergency Services and ask for ACLS.

Is the student capable and responsible for carrying and self-administering epinephrine?

YES _______ NO _______

Parent/Guardian Signature ____ Date ___________

Physician Signature ____ Date___________

Physician Stamp