

Attach a picture
of your student
here.

**FOOD ALLERGY AND ANAPHYLAXIS
EMERGENCY ACTION PLAN (EAP)**

Name _____ DOB _____ Grade/Teacher _____ School Yr. _____

ALLERGY TO: _____

Asthmatic? YES* _____ NO _____ *Higher risk for severe reaction

PRESCRIBED TREATMENT

Physician is to check the actions to be taken for each of the symptoms listed below.

SYSTEM	SYMPTOM	OBSERVE	EPINEPHRINE	ANTI-HISTAMINE
	Known ingestion with no symptoms			
Mouth	Itching, tingling or swelling of lips, tongue, mouth			
Skin	Hives, itchy rash, swelling of the face or extremities			
Gut	Nausea, abdominal cramps, vomiting, diarrhea			
Throat*	Tightening of throat, hoarseness, hacking cough			
Lung*	Shortness of breath, repetitive cough, wheezing			
Heart*	Weak, thready pulse, low blood pressure, fainting, pale, blueness			
Other				
	<i>Progressing Reaction: multiple systems involved</i>			

Items with an * are potentially life threatening. The severity of the symptoms can change quickly. Monitor for side effects of the epinephrine injection: nervousness, palpitations, fast heart rate, sweating, tremor, anxiety, dizziness, headache, nausea, vomiting, or weakness.

DOSAGE

Epinephrine: inject intramuscularly by auto-injector 0.3mg _____ 0.15mg _____

Give second epinephrine dose after _____ minutes if no improvement and EMS has not arrived.

Antihistamine: give _____

Other: _____

Physician's Name _____ **Phone** _____

Physician's Signature _____ **Date** _____