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 (please stamp below)

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:_____