ELLWOOD CITY AREA SCHOOL DISTRICT

501 CRESCENT AVE. ELLWOOD CITY, PA 16117
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FOOD ALLERGY ACTION PLAN

Student:		**Grade/Class:**	
ALLERGY TO:			
Is your student also diagnosed with asthma? YES **or** NO			
SYMPTOMS:	**Give Checked Medication:**		
If a food allergen has been ingested, but *no symptoms:*	( ) Epinephrine	( ) Antihistamine	( ) Other
Mouth: itching, tingling, or swelling of lips, tongue or mouth	( ) Epinephrine	( ) Antihistamine	( ) Other
Skin: hives, itching rash, swelling of the face or extremities	( ) Epinephrine	( ) Antihistamine	( ) Other
Gastrointestinal: nausea, cramps, vomiting or diarrhea	( ) Epinephrine	( ) Antihistamine	( ) Other
Airway: tightening of throat, hoarseness, or hacking cough	( ) Epinephrine	( ) Antihistamine	( ) Other
Lungs: shortness of breath, repetitive coughing, wheezing	( ) Epinephrine	( ) Antihistamine	( ) Other
Heart: Thready pulse, low blood pressure, fainting, pale, blueness	( ) Epinephrine	( ) Antihistamine	( ) Other
Other:_____	( ) Epinephrine	( ) Antihistamine	( ) Other
***If reaction is progressing (several of the above are affected), give:**	( ) Epinephrine	( ) Antihistamine	( ) Other
EPINEPHRINE:(name/dose/route)			
ANTIHISTAMINE:(name/dose/route)			
OTHER MEDICATION:(name/dose/route)			

IF EMERGENCY: CALL 911 !
Emergency Contact:(name/relationship/telephone number)
1.
2.
IF YOUR CHILD NEEDS MEDICATION FOR FOOD ALLERGIES, YOU WILL NEED TO SUPPLY THE MEDICATION AND NECESSARY FORMS WHICH CAN BE OBTAINED FROM THE SCHOOL HEALTH OFFICE OR THE SCHOOL WEBSITE.
Parent Signature: _____ Date:_____ Physician Signature: _____ Date:_____