UCAES FOOD ALLERGY ACTION PLAN

If child has multiple food allergies, please use separate form for each food.

_____ _____ _____

Student's Name: Date of birth: Teacher:

ALLERGY TO:_____

Asthmatic Yes No ***High risk for severe reaction** Yes No

►SIGNS OF AN ALLERGIC REACTION◄

Systems:	**Symptoms:**
▪ **MOUTH**	Itching and swelling of the lips, tongue, or mouth
▪**THROAT***	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
▪**SKIN**	Hives, itchy rash, and/or swelling about the face or extremities
▪**GUT**	Nausea, abdominal cramps, vomiting, and/or diarrhea
▪**LUNGS***	Shortness of breath, repetitive coughing, and/or wheezing
▪**HEART***	"Thready" pulse, "passing out"

****The severity of symptoms can quickly change. All above symptoms potentially can progress to a life-threatening situation.**

►ACTION PLAN FOR MINOR REACTION◄

If the only symptoms are:_____

then give_____.

medication/dose/route

Then call Mother_____, Father_____,

or emergency contacts_____.

Call Doctor _____at_____.

IF CONDITION DOES NOT IMPROVE WITHIN 10 MINUTES, FOLLOW STEPS FOR MAJOR REACTION.

►ACTION PLAN FOR MAJOR REACTIONS◄

If ingestion is suspected and/or symptoms are:_____

_____

then give_____**IMMEDIATELY!**

medication/dose/route

Call 911 and ask for advanced life support.

Call Mother_____, Father_____

or emergency contacts_____.

Call Doctor _____at_____.

NEVER HESITATE TO CALL 911

_____ _____

Parent's signature Date Doctor's signature Date