United School District
_____ School Year
Food Allergy Action Plan

Dear Parent/Guardian,

You have indicated on the emergency information card that your child has a food allergy. Please complete the information below and return this form to the School Health Office. Thank you for your cooperation.

Sincerely,
School Health Office
United School District
814-446-5615 #1319 (elem) or #2339 (hs)
****

Student's Name_____Grade_____

Food Allergy_____
What happens during the reaction?_____
Last time the student had this reaction? _____

SYMPTOMS - please checkmark

	Epinephrine	Antihistamine
• If food allergen has been ingested but no symptoms:	_____	_____
• Mouth-itching, tingling, swelling of lips or tongue	_____	_____
• Skin-hives, itchy rash, swelling of face, arms or legs	_____	_____
• Nausea, vomiting, abdominal cramping	_____	_____
• Tightening of throat, hoarseness, cough	_____	_____
• Shortness of breath, wheezing	_____	_____
• Thready pulse, low BP, fainting, pale or blueness	_____	_____
• Other:	_____	_____

MEDICATION

Epinephrine (circle one) EpiPen (0.3 mg) EpiPen Jr. (0.15mg) Auvi-Q (0.3mg) Auvi-Q (0.15 mg)

_____
(medication/dose/route/frequency)

Antihistamine: _____
(medication/dose/route/frequency)

Preferred Hospital: _____

Parent/Guardian Signature _____

*Physician Signature _____
*(required for medications)

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