

Food Allergy Emergency Action Plan

Patient Information

Child's Name: _____

Date of Birth: _____

Grade/Classroom: _____

Photo: _____ [Attach photo here]

ALLERGENS (Check all that apply):

<input type="checkbox"/> Peanut	<input type="checkbox"/> Tree Nuts: _____	<input type="checkbox"/> Milk
<input type="checkbox"/> Egg	<input type="checkbox"/> Wheat	<input type="checkbox"/> Soy
<input type="checkbox"/> Fish	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Sesame
<input type="checkbox"/> Other: _____		

SIGNS & SYMPTOMS OF AN ALLERGIC REACTION

MILD SYMPTOMS (May progress to severe):

- Itchy mouth, lips, or throat
- Hives, rash, or itchy skin
- Mild stomach pain or nausea
- Sneezing, runny nose
- Itchy, watery eyes

SEVERE SYMPTOMS (ANAPHYLAXIS) — ACT IMMEDIATELY:

- Difficulty breathing, wheezing, shortness of breath

- Swelling of tongue, lips, or throat
- Difficulty swallowing
- Dizziness, fainting, or loss of consciousness
- Pale or blue skin color
- Repetitive coughing
- Weak pulse
- Severe vomiting or diarrhea

EMERGENCY ACTION STEPS

**IF ANY SEVERE SYMPTOMS ARE PRESENT:
GIVE EPINEPHRINE IMMEDIATELY — DO NOT WAIT**

Step 1: INJECT EPINEPHRINE

- Inject epinephrine into outer thigh (can be given through clothing)
- Note the time of injection: _____

Step 2: CALL 911

- Tell them: 'Child is having anaphylaxis. Epinephrine has been given.'
- Request ambulance with epinephrine

Step 3: CALL PARENT/GUARDIAN

- Primary: _____ Phone: _____
- Secondary: _____ Phone: _____

Step 4: POSITION & MONITOR

- Lay child flat with legs elevated (unless having breathing difficulty — then let them sit up)
- Do NOT have child stand or walk
- If symptoms don't improve in 5-15 minutes, give SECOND dose of epinephrine

Step 5: TRANSPORT TO HOSPITAL

- Child MUST go to emergency room even if symptoms improve
- Symptoms can return (biphasic reaction)

MEDICATIONS ON FILE

Epinephrine Auto-Injector: EpiPen Auvi-Q Generic

Dose: 0.15 mg (Jr) 0.30 mg

Location of Medication: _____

Antihistamine: _____

Other Medications: _____

AUTHORIZATIONS

Parent/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Physician Name (Print): _____ **Phone:** _____

Wisconsin Food Allergy Institute
262-657-9390 | wisconsinfoodallergy.com
This form should be reviewed and updated annually.