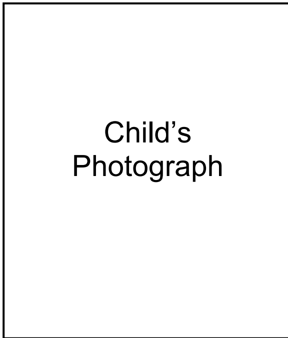
TRINITY PRESBYTERIAN NURSERY SCHOOL

FOOD ALLERGY EMERGENCY ACTION PLAN



CHILD'S NAME: ____________________________________ **D.O.B.** ____/___/___

CLASS: ___ **TWOs** ___ **TTH3s** ___ **MWF3s** ___ **MWF4s** ___ **PM4s**

___ **SEVERE ALLERGY TO:** ____

___ **MILD ALLERGY TO**: ____

___ **ASTHMA** (higher risk for severe reaction) **Weight:** _______ lbs

___ If checked, give epinephrine immediately for **ANY** symptoms if the allergen was ***likely*** eaten.
___ If checked, give epinephrine immediately, before symptoms if the allergen was ***definitely*** eaten.

SEVERE SYMPTOMS → INJECT EPINEPHRINE IMMEDIATELY

ONE OR MORE OF THE FOLLOWING:

- **LUNGS** Short of breath, wheezing, repetitive cough
- **HEART** Pale, blue, faint, weak pulse, dizzy
- **THROAT** Tight, hoarse, trouble breathing/swallowing
- **MOUTH** Obstructive swelling (tongue and/or lips)
- **SKIN** Many hives over body

OR A COMBINATION OF SYMPTOMS:

- **SKIN** Hives, itchy rashes, swelling (e.g., eyes, lips)
- **GUT** Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- **CALL 911**
- BEGIN MONITORING (see below)
- Note time epinephrine was administered __________
- Give inhaler / bronchilator if asthmatic

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY → GIVE ANTIHISTAMINE

ONE OR MORE OF THE FOLLOWING:

- **MOUTH** Itchy mouth
- **SKIN** A few hives around mouth / face, mild itch
- **GUT** Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child; alert healthcare professionals and parent
- **IF SYMPTOMS PROGRESS, INJECT EPINEPHRINE** (see above)

MONITORING

Stay with the child; alert healthcare professionals and parent. Advise paramedics epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose may be administered 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

MEDICATIONS

EPINEPHRINE: Brand ______________________________ Dose ______________

ANTIHISTAMINE Brand ______________________________ Dose ______________

OTHER (e.g. inhaler / bronchilator) Brand ______________________________ Dose ______________

EMERGENCY CONTACTS

Parent/Guardian: ____________________________________ Phone: ________________

Parent/Guardian: ____________________________________ Phone: ________________

Name/Relationship: __________________________________ Phone: ________________

Name/Relationship: __________________________________ Phone: ________________

______________________________ ________ ______________________________ ________

Parent/Guardian Signature Date Physician/Healthcare Provider Date