West Ch	nester Area School Distric	t: FOOD ALLERGY AC	TION PLAN (www.foodallergy.com)	
Na <u>me:</u>			D.O.B.:	
Allergy				
Weight:	lbs. Asthma: [ ] Yes (hig	her risk for a severe r	reaction) [ ] No	
NOTE: Do no	t depend on antihistamines or	inhalers (bronchodilators	s) to treat a severe reaction. USE EPINEPHRINE.	
Extremely reactive to	the following allergen	ns:		
			THEREFORE:	
		_	LIKELY eaten, for ANY symptoms.  DEFINITELY eaten, even if no symptoms are	
FOR <b>ANY</b> OF THE FOLLOWING:			MILD SYMPTOMS	
<b>SEVERE</b> SYMPTOMS				
LUNG HEAR Short of Breath, Wheezing, weak pu	_	MOUTH Significant swelling tongue/and or lips	NOSE MOUTH SKIN GUT  Itchy/Runny Itchy Mouth Nose, sneezing Mild Nausea/  Mild Nausea/  Mild Nausea/  discomfort	
epetitive cough breathing/swallow		-	FOR <b>MILD SYMPTOMS</b> FROM <b>MORE THAN ONE</b> SYSTEM AREA, GIVE EPINEPHRINE.	
Many hives over Reper Body, widespread seven Redness	OTHER titive vomiting re diarrhea anxiety, co	nfusion body areas	SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:  1. Antihistamines may be given, if ordered by a healthcare provider.  2. Stay with the person; alert emergency contacts.	
2. <b>Call 911.</b> Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.			3. Watch closely for changes. If symptoms worsen, give epinephrine.	
<ul><li>Consider giving additi</li><li>» Antihistamine</li></ul>	ional medications following odilator) if wheezing		MEDICATIONS/DOSES	
<ul> <li>Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.</li> </ul>			Epinephrine Brand or Generic:  Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM	
<ul> <li>If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.</li> <li>Alert emergency contacts.</li> </ul>			Antihistamine: Other (e.g., inhaler-bronchodilator if wheezing):	
Transport patient to I	ER, even if symptoms resolv urs because symptoms may		1	
Physician/HCP		Date:	Student May Self Administer: ( ) Yes ( ) No	
Parent/Guardian		Date:	_	