Food Allergy Emergency Plan

This form must be completed by the child's health care professional and returned before the child will be admitted to First Friends Preschool @ TBC.

Student's Name: _____ Date of Birth: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ___ **Yes (higher risk for severe reaction)** ___ **No**

	SYMPTOMS	Give checked medication as determined by Physician	
Place a check next to symptoms student may experience if exposed to an allergen		**Antihistamine**	**Epinephrine**
	If an exposure to the allergen has occurred, but there are NO symptoms:		
	Mouth: Itching, tingling, or swelling of lips, tongue, mouth		
	Skin: Hives, itchy rash, swelling of the face or extremities		
	●**Gut**: Nausea, abdominal cramps, vomiting, diarrhea		
	●**Throat**: Tightening of throat, hoarseness, hacking cough		
	●**Lung**: Shortness of breath, repetitive coughing, wheezing		
	●**Heart**: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
	Other symptoms:		
	If reaction is progressing, several of the above areas affected:		

● Potentially life threatening. The severity of symptoms can quickly change.

Dosage:

◯ EpiPen® ◯ EpiPen® Jr. ◯ Twinject® 0.3 mg ◯ Twinject® 0.15 mg

Antihistamine: _____

Medication/Dose/Route

Other: _____

Medication/Dose/Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Emergency Calls

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parent: Mother: _____ Number: _____
   Father: _____ Number: _____
3. Doctor: _____ Phone Number: _____
4. Other Emergency Contacts:
   Name: _____ Number: _____
   Name: _____ Number: _____
   Name: _____ Number: _____

Even if Parent/Guardian cannot be reached, do not hesitate to medicate or have child transported to a medical facility.

Parent/Guardian Signature: _____ Date: _____

Physicians Signature: _____ Date: _____