Rainbow District School Board

Food Allergy Action Plan

ALLERGY TO: _____

STUDENT NAME: _____

DATE OF BIRTH: _____
DD/MMM/YYYY

TEACHER: _____

SCHOOL: _____

PLACE CHILD'S PICTURE HERE

ASTHMATIC? ☐ **YES*** ☐ **NO** ***HIGH RISK FOR SEVERE REACTION**

SIGNS OF AN ALLERGIC REACTION

SYSTEMS	SYMPTOMS
MOUTH	Itching and swelling of the lips, tongue or mouth
THROAT**	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG**	Shortness of breath, repetitive coughing, and/or wheezing
HEART**	"Thready" pulse, "passing out"

****ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION**
THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE

ACTION FOR MAJOR ALLERGIC REACTION

1. If ingestion is suspected and/or symptom(s) are: _____ ,
   give _____ **IMMEDIATELY!**
   medication/dose/route

THEN CALL:

2. **911**

3. **Parent** _____ at _____
   Parent _____ at _____

   OR Emergency Contacts
   _____ at_____
   _____ at_____

4. **Doctor** _____ at _____

DO NOT HESITATE TO CALL 911

PARENT'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

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