Tyndall AFB CYP Food Allergy/Intolerance Action Plan

Child's Name: ______________________________ D.O.B:__________________

Allergy/ Intolerance to: ____

[ ] If box checked, there is no medical attention needed if contact is made with allergen/intolerant.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG: shortness of breath, wheezing, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy

THROAT: Tightness, hoarseness, difficulty swallowing

MOUTH: Significant swelling of the tongue and/or lips

SKIN: Diffuse hives, widespread redness

GUT: Repetitive vomiting, severe diarrhea

OTHER: Feeling something bad is about to happen, anxiety, confusion / altered mental status

OR A COMBINATION of symptoms from different body areas (e.g hives + vomiting; throat tightness + hives; etc).

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911**. Tell them the child is in anaphylaxis and may need epinephrine when they arrive.
   - Consider giving additional medications following epinephrine:
     >> Antihistamine
     >> Inhaled bronchodilator if wheezing / resp distress
   - Lay the person flat, raise legs and keep warm. If breathing is difficult or he/she is vomiting, let him/her sit up or lie on his/her side.
   - If symptoms fail to improve, worsen, or return, additional doses of epinephrine can and should be given 5-10 minutes or more after the last dose.

For **ANY** OF THE FOLLOWING:

MILD SYMPTOMS

NOSE: Itchy/runny nose, sneezing

MOUTH: Itchy mouth

SKIN: A few hives, mild itch or redness

GUT: Mild nausea/discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE 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.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/ DOSAGE

Epinephrine Brand: ________________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine name, dose, and frequency:
____

Other (e.g. inhaled bronchodilator if wheezing):________________________________

STEP 2: EMERGENCY CALLS

Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

Parent/Guardian Authorization Signature ______________________ Date

Physician/HCP Authorization Signature and Stamp ______________________ Date