

# WILMINGTON PUBLIC SCHOOLS

## Food & Insect Allergy Action Plan

Place  
Student's  
Picture  
Here

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  YES (higher risk for severe reaction)  NO

**Extremely reactive to the following foods:** \_\_\_\_\_

**THEREFORE:**

- Give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten
- Give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms noted

**Any SEVERE SYMPTOMS after suspected or known Ingestion:**

**One or more** of the following:

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

**Or combination** of symptoms from different body areas:

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



**1. INJECT EPINEPHRINE IMMEDIATELY**

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications\*
  - Antihistamine
  - Inhaler for Asthma

\*Antihistamine & Inhalers are not to be depended upon to treat a severe reaction (anaphylaxis),  
**USE EPINEPHRINE**

**Medication/Dose:**

Epinephrine brand:

- Epipen
- Auvi-Q

Epinephrine dose:

- 0.3 mg Adult IM  May repeat 0.3 mg Adult IM
- .15 mg Child IM  May repeat .15 mg Child IM

- Consent for self-administration/self-carry (provided the school nurse determines it is safe and appropriate)

**Monitoring: *Stay with student, alert healthcare professionals and parent.***

Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine may be administered if applicable (see prescription label). For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See Page 2 for auto-injection technique.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Healthcare Provider Signature

\_\_\_\_\_  
Date

