Conroe Independent School District

Food Allergy Action Plan

Student _____ Grade _____ Teacher(s) _____

Allergy to: _____

Asthma ☐ *yes* ☐ *no* ***If yes**, high risk for severe reaction*

Previous reaction was _____

Minor Reaction

☐ localized swelling
☐ itching without rash or hives
☐ nausea
☐ runny nose
☐ watery eyes
☐ abdominal cramps

Give medication _____ dose _____

route _____ frequency _____

Then call ☐ mother home _____ work _____

cell _____ Other _____

☐ father home _____ work _____

cell _____ Other _____

☐ doctor _____

If the condition does not improve in 10 minutes, follow steps for Major Reaction.

Major Reaction

☐ swelling & itching of lips, tongue or mouth
☐ itching or sense of tightness in throat, hoarseness, or hacking cough
☐ hives or swelling around the face or extremities
☐ vomiting
☐ shortness of breath, wheezing, or repetitive cough
☐ thready pulse
☐ loss of conscienceness

Give medication _____ dose _____

route _____ frequency _____

Then call ☐ EMS *911 - Ask for advanced life support*

☐ mother home _____ work _____

cell _____ Other _____

☐ father home _____ work _____

cell _____ Other _____

☐ doctor _____

_____ _____

Parent's signature *Date*

Notify *(initial/date)* Nurse _____ Teacher _____ Cafeteria _____ Specials _____ Principal _____