FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Food Allergy Statement & Medical Emergency Plan

Name of Child: _____ Date of Birth _____ / _____ / _____

Name of Parent/Guardian: _____Phone: _____

Asthma ☐ Yes ☐ No
Non-Food Allergy(s) _____

Food Allergies _____

Other _____

Signs of an allergic reaction

Systems:	Symptoms:
Mouth	Itching & swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness & 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"

Action for Minor Reaction

If symptoms(s) are: _____

Administer: _____

Medication/dose/route

Then call: Parent/Guardian and Doctor
If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

Action for Severe Reaction

If symptoms(s) are: _____

Administer: _____ **Immediately!**

Medication/dose/route

Call: 911, then Parent/Guardian, then doctor

Any other instructions:

_____

_____

_____

Parent/Guardian _____Phone _____ Cell phone _____

Parent/Guardian _____Phone _____ Cell phone _____

Doctor _____Phone _____

Signature of Parent/Guardian _____ Date _____

Doctor's signature (required) _____ Date _____

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