Food Allergy Action Plan

Child's Name	Child's DOB:
Child is Allergic to:	

Check only one box for type of reaction (mild, severe or special situation) if exposed to allergen, then select or write in symptoms that apply:

□	**MILD REACTION (check symptoms that apply)** □itchy nose □sneezing □itchy mouth □a few hives □mild stomach discomfort/nausea **Other/s not listed:**
	Actions for PRCS staff to take if child is exhibiting symptoms of a mild reaction to listed allergy:
□	**SEVERE ALLERGIC REACTION (check symptoms that apply)** □shortness of breath □wheezing □skin color is pale or has bluish color □weak pulse □fainting or dizziness □tight or hoarse throat □agitation □feeling of "doom" □trouble breathing or swallowing □vomiting/diarrhea □many hives or redness over body □coughing □confusion, altered consciousness □swelling lips or tongue that bother breathing **Other/s not listed:**
□	**SPECIAL SITUATION-**Child has EXTREME severe allergy to food(s) and requires an epinephrine immediately if exposed to allergen, even if symptoms are mild.

Please select all steps applicable for PRCS Staff to take if your child is exposed to listed allergy:

□	Administer antihistamine as prescribed on PRCS medication authorization form, call parents
□	Administer antihistamine as prescribed on PRCS medication authorization form, call parents. Monitor child. If symptoms worsen, inject epinephrine as prescribed on PRCS medication authorization form, call 911, call parents
□	Inject epinephrine immediately, noting time given, call 911, call parents
□	Inject epinephrine immediately, noting time given, call 911, give antihistamine if prescribed, call parents
□	Other:

I, (parent/guardian)_____, have reviewed and discussed the above Food Allergy and Anaphylaxis Emergency Care plan with my child's physician, and authorize Loudoun County Parks, Recreation and Community Services staff to follow the Food Allergy and Anaphylaxis Emergency Care Plan as documented on this form should my child be exposed to the above listed allergy.

Parent/Guardian Signature: **Date:**

Physician Signature: **Date:**

Revised 8/4/22