United School District  
____School Year  
Food Allergy Action Plan

Dear Parent/Guardian,

You have indicated on the emergency information card that your child has a food allergy. Please complete the information below and return this form to the School Health Office. Thank you for your cooperation.

Sincerely,
School Health Office  
United School District  
814-446-5615 #1319 (elem) or #2339 (hs)

Student’s Name ____________________________ Grade ______

Food Allergy __________________________________________

What happens during the reaction? __________________________

Last time the student had this reaction? __________________________

**SYMPTOMS**

- If food allergen has been ingested but no symptoms: Epinephrine _______ Antihistamine _______
- Mouth-itching, tingling, swelling of lips or tongue _____________
- Skin-hives, itchy rash, swelling of face, arms or legs ______
- Nausea, vomiting, abdominal cramping _____________
- Tightening of throat, hoarseness, cough _____________
- Shortness of breath, wheezing _____________
- Thready pulse, low BP, fainting, pale or blueness ______
- Other: _____________

**MEDICATION**

**Epinephrine (circle one) EpiPen  EpiPen Jr.  Twinject 0.3mg  Twinject 0.15mg**

Antihistamine: ____________________________ (medication/dose/route)

Other: ____________________________ (medication/dose/route)

Preferred Hospital: ____________________________

Parent/Guardian Signature _____________________________________________________________________

*Physician Signature ________________________________________________________________________  
* (required for medications)