



Allergy Action Plan

Student Name _____ D.O.B. _____ Teacher/Grade: _____

ALLERGY: To be completed by Health Care Provider (check appropriate)

- Foods (list): _____
- Medications (list): _____
- Latex: (circle) Type I (anaphylaxis) and/or Type IV (contact dermatitis)
- Stinging insects (list): _____

ASTHMATIC: Yes (Higher risk for severe reaction)

STEP 1: TREATMENT

Symptoms

Give Checked Medication

(To be determined by physician authorizing treatment)

- Has come in contact with allergen, but “no symptoms”
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat* Tightening of throat, hoarseness, hacking cough
- Lung* Shortness of breath, repetitive coughing, wheezing
- Heart* Thready pulse, low blood pressure, fainting, pale, blueness
- Other* _____
- If reaction is progressing (several of the above areas affected), give

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. *Potentially life threatening

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr. _____ Phone: _____
3. Emergency Contacts: Name/Relationship Phone Numbers

	1. _____ 2. _____
	1. _____ 2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ **Date** _____

Doctor Signature (Required) _____ **Date** _____