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 1 (anaphylaxis) and/or Type IV (contact dermatitis)
- ☐ Stinging insects (list): _____
- ☐ Other: _____

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"		☐ Epinephrine ☐ Antihistamine
• Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Other*	_____	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ Epinephrine ☐ 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** _____