Allergy Action Plan

Picture here

Student's Name: _____ **D.O.B:**_____ **Teacher/Grade:** _____

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:	**Give Checked Medication**:**
	**(To be determined by physician authorizing treatment)
• If been 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.

Antihistamine:
give_____
medication / dose / route

Other:
give_____
medication / dose / route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parents_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

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

Parent/Guardian Signature_____ Date_____
(Required)

Doctor's Signature_____ Date_____
(Required)