Allergy Action Plan

Student's Name: _____ **D.O.B.:** _____ **Class:** _____

Allergy to: _____

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

STEP 1 : TREATMENT

Symptoms:		Give Checked Medication** (please circle below)	
If an allergen has been ingested (food, sting), 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
GI:	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
Throat:	Tightening, 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 above areas affected), give:		Epinephrine	Antihistamine

DOSAGE: ** To be determined by physician authorizing treatment

Antihistamine: give: _____
medication/dose/route/frequency

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

Other: give: _____
medication/dose/route/frequency

Doctor's Signature: _____ Date: _____

Print Name : _____ Office Phone Number: _____

STEP 2 : EMERGENCY CALLS

1 **CALL 911** State that an allergic reaction has been treated, and additional epinephrine may be needed. Send used epinephrine injection device with student to Emergency Room.

2 **CALL Parent:** _____ Phone Number: _____

3 **CALL Emergency Contacts:** Phone Number(s):

1) _____ _____

2) _____ _____

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of named student, request this emergency action plan be used to guide allergy care for my child.

I agree to:

1) provide necessary supplies and equipment, including EpiPen and Benadryl as prescribed.
2) notify the school office of any changes in the student's health status.
3) notify the school office and complete new action plan when any changes to this plan are made by the student's health care provider.
4) authorize the school to communicate with the primary care provider/specialist (listed above) about allergy as needed.
5) allow the school staff interacting directly with my child to be informed about his/her special needs while at school.

Parent/Guardian Signature: _____ Date: _____