Allergy Action Plan

Student's Name_____D.O.B._____Teacher_____

Place Child's Picture Here

ALLERGY TO:_____

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

♦STEP 1: TREATMENT♦

Symptoms:		**Give Checked Medication**:** (**(to be determined by provider authorizing treatment))
▪	If food allergen has been ingested or allergen has been contacted, 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 (see reverse side for instructions)

Student can self carry medication? Yes ☐ No ☐. Student can self-administer medication? Yes ☐ No ☐

Epinephrine is stored: ☐ In Health Room ☐ Student carries medication ☐ Other_____

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 (or Emergency Medical Services_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Provider:_____at_____.
3. Emergency contacts:

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

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

Parent/Guardian Signature_____ Date_____

Provider Signature_____ Date_____