Diocese of Corpus Christi
Office of Catholic Schools
Life Threatening Allergy Action Plan

Student Name: _____ Date of birth: _____

Allergy: _____

_____☐_____ if checked, give epinephrine for ***ANY*** symptom related to *definite* or *likely* exposure.

_____☐_____ if checked, give epinephrine immediately for *definite* exposure, even if no symptoms noted.

Severe symptoms after definite or likely contact to Allergy:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or *combination of symptoms* from different body areas:

Skin: Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut: Vomiting, crampy pain

PLAN A

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. CALL 911
3. Begin monitoring
4. Give additional medications: * Inhaler/Bronchodilator, Antihistamine

*Antihistamines & Inhalers/Bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).

USE EPINEPHRINE

Mild symptoms after definite or likely contact to Allergy:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

PLAN B

1. **GIVE ANTIHISTAMINE**
2. Stay with student: alert health care professionals and parent
3. IF symptoms progress **(see above Plan A**), USE EPINEPHRINE and CALL 911
4. Begin monitoring

Medications/Doses: As per Diocesan Medication Administration Form on file

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator):_____

Clinician Name Sign: _____

Clinician Name Print: _____

Date: _____

Clinician Office Number: _____