MT. BETHEL CHRISTIAN ACADEMY
a 2018 National Blue Ribbon School

School Year: _____

Allergy Action Plan

(Must be completed by Physician)

Student Name: _____ DOB: _____ GRADE: _____

Allergic to: _____

Asthmatic: YES* _____ NO _____ (* At higher risk for severe reaction)

*** STEP 1: TREATMENT ***

SYMPTOMS	GIVE CHECKED MEDICATION
• If stung, but no symptoms:	___Epinephrine ___ Antihistamine
• If allergen is ingested, 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, vomiting, diarrhea, abdominal pain	___Epinephrine ___ Antihistamine
• Throat: Tightening of throat, hoarseness, swelling of uvula or oral mucosa	___Epinephrine ___ Antihistamine
• Lung: Shortness of breath, coughing, wheezing	___Epinephrine ___ Antihistamine
• Heart: Weak pulse, low blood pressure, fainting, pallor, cyanosis	___Epinephrine ___ Antihistamine
• Other: _____	___Epinephrine ___ Antihistamine
• If reaction is progressing (several of the above areas affected), give:	___Epinephrine ___ Antihistamine

** SYMPTOMS AFFECTING THE THROAT, HEART AND LUNGS CAN WORSEN QUICKLY AND BE POTENTIALLY LIFE-THREATENING **

MEDICATIONS:

EPINEPHRINE: INJECT INTRAMUSCULARLY (CIRCLE): EPI-PEN 0.3 MG EPI-PEN JR. 0.15 MG

AUVI-Q 0.3 MG AUVI-Q 0.15 MG

ANTIHISTAMINE (ORAL): _____ DOSAGE: _____FREQUENCY: _____

INHALER: _____ DOSAGE: _____FREQUENCY: _____

OTHER: _____

*** STEP 2: EMERGENCY CALLS ***

1) **CALL 911 – State that a severe allergic reaction has been treated with epinephrine. and additional epinephrine may be needed.**

2) **Call Parent/Guardian or Emergency Contacts:**

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

3) **Physician: _____ Phone: _____**

*** EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND/OR TRANSFER CHILD TO A MEDICAL FACILITY ***

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____