

Allergy Action Plan

Student's Name: _____ DOB: _____

Allergy To: _____

Asthmatic: YES* NO *higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give CHECKED medication determined by Physician:

If a food allergen has been 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, 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 – weak or thread pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other – feeling something bad is about to happen, anxiety, confusion	Epinephrine	Antihistamine
Or a combination from different body areas	Epinephrine	Antihistamine

DOSAGE:

Epinephrine: inject intramuscularly (circle one)

EpiPen AUVI-Q ADRENALIN

Antihistamine: give _____

Other: give _____

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: _____
(Print name)

3. Parent _____ Phone Number: _____

4. Emergency Contacts:

Name/Relationship

Phone Numbers

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's signature

Date

Doctor's signature

Date