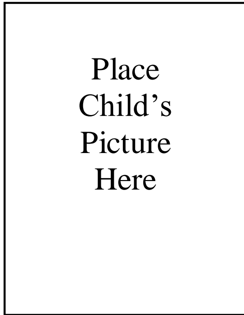
Allergy Action Plan



Student's Name: ______________________________ **D.O.B.:** ____________ **Teacher:** ______________________

ALLERGY TO: ____

Asthmatic? Yes* ☐ **NO** ☐ *** Higher risk for severe reaction**

◆ STEP 1: TREATMENT ◆

Symptoms:	**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪ 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® 0.3mg** **EpiPen® Jr. 0.15mg**

(see reverse side for instructions)

Antihistamine: give ____
Medication/dose/route

Other: give ____
Medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: __________________) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ___________________________________ at ___________________________________
   Physician's Name Printed — Doctor's phone number

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 HEISTATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY:

Parent/Guardian Signature ____ Date: ____________________

Doctor's Signature ____ Date: ____________________