Maclay School

Individualized Student Allergy Action and Care Plan for 2023-2024 School Year

Student's Name: _____ DOB: _____

Grade Level: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthma Diagnosis (circle one)? Yes* or No *Higher risk for severe reactions

STEP 1: TREATMENT – This section to be completed by PHYSICIAN authorizing treatment

Symptoms:	**Give Checked Medications:**	
▪ If exposed to allergen, 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
▪ Lungs †: 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

MEDICATION AND DOSAGE:

Epinephrine: Inject intramuscularly (circle one or list) EpiPen EpiPen Jr. Other: _____

Antihistamine: Give by mouth _____

Other: Give (medication/dose/route) _____

STEP 2: EMERGENCY CALLS

1. **Call 911 – State that an allergic reaction has been treated and additional epinephrine may be needed. DO NOT HESITATE TO MEDICATE OR CALL 911 IF PARENT/GUARDIAN CANNOT BE REACHED.**
2. Dr. _____ at _____
3. Emergency Contacts: Name/Relationship Phone Number
   1) _____ primary number _____
   2) _____ primary number _____
   3) _____ primary number _____

LOCATION OF INTRAMUSCULAR EPINEPHRINE: _____

Parent/Guardian Signature _____ Date _____

Physician's Signature _____ Date _____

Reviewed by Maclay School RN Signature: _____Date _____