

ALLERGY ACTION PLAN

Place
Child's
Photo
Here

Last Name: _____ First Name: _____

DOB: _____ Allergic to: _____

Asthmatic: Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms	Give CIRCLED Medication (Determined by physician authorizing treatment)	
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 F : Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Lung F : Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart F : Weak or thread pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other F : _____	Epinephrine	Antihistamine
If reaction is progressing (several of the above areas affected), give:	Epinephrine	Antihistamine

F: Potentially life-threatening. The severity of symptoms can quickly change.

Dosage

Epinephrine: inject intramuscularly (*circle one*): EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give _____
(medication/dose/route)

Other: give _____
(medication/dose/route)

IMPORTANT: Asthmas inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

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. _____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency Contacts:
 - a. _____ Phone Number(s): _____
 - b. _____ Phone Number(s): _____

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

(Required)