Emergency Allergy Action Plan

Student Name: _____ **DOB:**_____ **Grade:** _____

Allergy to: _____ **Asthmatic:** ⬜Yes (Higher risk for severe reaction) ⬜No

SEVERE SYMPTOMS:		Give Checked Medication:	
Mouth	Itching, tingling, significant swelling of tongue or lips	⬜Epinephrine	⬜ Antihistamine
Skin	Many hives over body, widespread redness	⬜Epinephrine	⬜ Antihistamine
Gut	Repetitive vomiting, severe diarrhea	⬜Epinephrine	⬜ Antihistamine
Throat	Tight or hoarse throat, trouble breathing or swallowing	⬜Epinephrine	⬜ Antihistamine
Lung	Shortness of breath, repetitive cough, wheezing	⬜Epinephrine	⬜ Antihistamine
Heart	Pale or bluish skin, faintness, weak pulse, dizziness	⬜Epinephrine	⬜ Antihistamine
Other	Feeling something bad is about to happen, anxiety, confusion	⬜Epinephrine	⬜ Antihistamine
If a food allergen has been ingested, but *no symptoms*:		⬜Epinephrine	⬜ Antihistamine
FOR ANY OF THE ABOVE **SEVERE** SYMPTOMS **GIVE EPINEPHRINE IMMEDIATELY**!			
FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE!			
Mild symptoms may include: itchy/runny nose, sneezing, itchy mouth, a few hives, mild itch, mild nausea or GI discomfort			

MEDICATIONS / DOSES

Epinephrine Brand/Generic: _____ **Epinephrine Dose:** ⬜ **0.1 mg IM** ⬜ **0.15 mg IM** ⬜ **0.3 mg IM**

Antihistamine Brand/Generic: _____ **Antihistamine Dose/Route:** _____

Other: (e.g., inhaler-bronchodilator if wheezing)_____

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

EMERGENCY CONTACTS

Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.

Doctor: _____ Phone Number:_____

Parent/Guardian: _____ Phone Number:_____

Name/Relationship _____ Phone Number:_____

IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE and CALL 911!

PLEASE REVIEW, SIGN AND RETURN THIS FORM TO THE SCHOOL NURSE.

*The information above is correct and should be used in the event of an allergic reaction at school.
*The School Nurse may share this Allergy Action Plan and a photo with all school/transportation personnel interacting with my student.
*The School Nurse may contact the doctor listed above to discuss this information.
*If the student is sent to the emergency department, a follow-up report may be faxed to the School Nurse.

Parent/Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

SCHOOL YEAR: _____ **Teacher:** _____