

Allergy Action Plan (LATEX)

School Year 20____ to 20____

Name _____

DOB ____/____/____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

↓Emergency Plan (to be completed by physician)

Treatment

Symptoms

■ If exposure to latex has occurred, but *no symptoms*:

- | | |
|------------|--|
| ■ Site | Swelling, redness, itching |
| ■ Skin | Itching, tingling or swelling of lips, tongue, mouth |
| ■ Gut | Nausea, abdominal cramps, vomiting, diarrhea |
| ■ Throat ♦ | Tightening of throat, hoarseness, hacking cough |
| ■ Lung ♦ | Shortness of breath, repetitive coughing, wheezing |
| ■ Heart♦ | Thready pulse, low BP, fainting, pale, blueness |
| ■ Other♦ | _____ |

Give Checked Medication

☐ EpiPen ☐ Antihistamine

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■ If reaction is progressing (several of the above areas affected), give _____
The severity of symptoms can quickly change. ♦Potentially life threatening

Dosage

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr

Dose: _____mg

Antihistamine: Give _____
medication/dose/route

Other: Give _____
medication/dose/route

Emergency Calls

1. **Call 911.** State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call Parent/Guardian _____ Home phone _____
Work phone _____ Cell phone _____
3. Dr. _____ at _____
4. Emergency Contact (if parent cannot be reached) _____
Phone _____

Parent/Guardian Signature _____

Physician Signature _____

Physician Printed Name _____ Address _____