GHC | GRANADA HILLS CHARTER

BRIAN BAUER
CHIEF EXECUTIVE OFFICER/SUPERINTENDENT

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ALLERGY ACTION PLAN

Student's Name: _____ID:_____DOB: _____

Allergen:_____

Reaction:_____

Student is prescribed the following (Please check)

◯ **Epinephrine 0.3mg intramuscular** ◯ **Antihistamine Name: _____**

Mouth: **Itching, tingling, swelling of lips, tongue, mouth** **____ Epinephrine** **____ Antihistamine**

Integumentary: **Hives, swelling of the face or extremities** **____ Epinephrine** **____ Antihistamine**

Gastrointestinal: **Nausea, abdominal cramps, vomit, diarrhea** **____ Epinephrine** **____ Antihistamine**

Throat: **Tightening of throat, hoarseness, hacking cough** **____ Epinephrine** **____ Antihistamine**

Respiratory: **Shortness of breath, repetitive cough, wheezing** **____ Epinephrine** **____ Antihistamine**

Cardiovascular: **Thready pulse, low BP, faint, pale, cyanosis** **____ Epinephrine** **____ Antihistamine**

If symptoms do not improve within _____minutes **____ Give 2nd Epinephrine Injection**

Other Special Instructions: _____.

Parent/Guardian Signature Required_____Date_____

Physician Signature Required _____Date_____

Medical Office Stamp (Required)

OFFICE USE (Do Not Write in This Box)

Date Form Received _____ Med Received ◯ Y ◯ N Quantity _____ Nurse_____ Parent _____

Date Med Returned _____ Parent/Guardian Signature _____ Nurse _____