

School Nurse Phone: (818) 360-2361 ext. 389 Fax: (818) 363-0103

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 _____