Allergy Action Plan

Student's Name: _____DOB:_____

Allergy To: _____

Asthmatic: YES* NO *higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: **Give CHECKED medication determined by Physician:**

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 – tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Lung – shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart – weak or thread pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other – feeling something bad is about to happen, anxiety, confusion	Epinephrine	Antihistamine
Or a combination from different body areas	Epinephrine	Antihistamine

DOSAGE:

Epinephrine: inject intramuscularly (circle one)

EpiPen AUVI-Q ADRENACLICK

Antihistamine: give_____

Other: give_____

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr._____ Phone Number:_____
   (Print name)
3. Parent_____ Phone Number:_____
4. Emergency Contacts:

   Name/Relationship Phone Numbers

   a._____ 1) _____2) _____

   b._____ 1) _____2) _____

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

_____ _____ _____ _____

Parent's signature **Date** **Doctor's signature** **Date**