

## Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

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

### ◆ STEP 1: TREATMENT ◆

**Symptoms:**

**Give Checked Medication\*\*:**

(To be determined by physician authorizing treatment)

- |  |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
|--|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|
| <ul style="list-style-type: none"> <li>▪ If a food allergen has been ingested, but <i>no symptoms</i>:</li> <li>▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth</li> <li>▪ Skin Hives, itchy rash, swelling of the face or extremities</li> <li>▪ Gut Nausea, abdominal cramps, vomiting, diarrhea</li> <li>▪ Throat† Tightening of throat, hoarseness, hacking cough</li> <li>▪ Lung† Shortness of breath, repetitive coughing, wheezing</li> <li>▪ Heart† Thready pulse, low blood pressure, fainting, pale, blueness</li> <li>▪ Other† _____</li> <li>▪ If reaction is progressing (several of the above areas affected), give</li> </ul> | <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> </table> | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |
| <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine   |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |                                      |  |

The severity of symptoms can quickly change. †Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

### ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

St. Francis High School Health Office

Dear Parent of \_\_\_\_\_

Please complete and return this form to the health office before the start of the school year. Thank You, *LuAnn Starzynski RN*

Your son's health record indicates an allergy to :

\_\_\_\_\_ Bee Stings                      \_\_\_\_\_ Peanuts

\_\_\_\_\_ Peanut oil                      \_\_\_\_\_ Latex

\_\_\_\_\_

**BEE STING**

Date of last bee sting \_\_\_\_\_

• **Reaction symptoms**

\_\_\_\_\_

• **Care needed ( ex; Benadryl\*, Epi-pen\*, Emergency room\* )**

\_\_\_\_\_

**PEANUT/ PEANUT OIL**

**Other** \_\_\_\_\_

Date of last reaction \_\_\_\_\_

• **Reaction symptoms**

\_\_\_\_\_

• **Care needed ( ex; Benadryl\*, Epi-pen\*, Emergency room\* )**

\_\_\_\_\_

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

**\* If your son requires medication for an allergic reaction, you need to provide the school with the medication and an allergy action plan completed by you and your son's physician. (See reverse side)**