TRINITY BASIN PREPARATORY

ALLERGY ACTION PLAN

Name	Date
Doctor:	
Doctor's Phone #:	
Doctor's Signature:	
ALLERGY:	

Student has Asthma: ☐ Yes ☐ No

Student has had anaphylaxis: ☐ Yes ☐ No

Student may self administer Epi Pen: ☐ Yes ☐ No

☐ **Child has severe allergy! Even if student only has mild symptoms, give Epinephrine!**

MILD REACTION	DO THIS:	Medications
Any/All of these: *Itchy nose *sneezing *itchy mouth *A few hives *Mild nausea *Mild stomachache	*Stay with student *Give prescribed medications *Call Parents *Monitor for worsening symptoms	☐ Epi Pen ☐ Antihist-amine ☐ Inhaler ☐

SEVERE REACTION	DO THIS:	Medications
ANY of these: *Shortness of breath, wheezing, coughing *Pale or bluish skin color *Weak Pulse *Tight or hoarse throat *Trouble breathing/swallowing *Swelling of lips or tongue *Vomiting or diarrhea *Many or full-body hives *Felling of "doom", confusion, altered consciousness, or agitation	*Stay with student Give Prescribed Medications *Call 911 (ask for ambulance with epinephrine and tell squad when epi was given. *Call for backup (Notify admin and ask for help contacting parents, arranging transport, write down interventions, ect)	☐ Epi Pen ☐ Antihist-amine ☐ Inhaler ☐

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ALLERGY ACTION PLAN

Name	Date
Doctor:	
Doctor's Phone #:	
Doctor's Signature:	
ALLERGY:	

Contacts

Parent/Guardian:_____ Phone: ___-___-____

Parent/Guardian: _____ Phone:___-___-____

Other Emergency Contacts

Name/Relationship:_____ Phone: ___-___-____
Name/Relationship: _____ Phone:___-___-____

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

Parent/Guardian Signature: _____ Date: __/__/____

Physician Signature: _____ Date: __/__/____