

SOUTHAMPTON TOWNSHIP SCHOOLS

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ALLERGY ACTION PLAN

School Year: 20__ - 20__ Grade: _____

Name of Child: _____ D.O.B. _____

ALLERGIC TO: _____

STEP 1: TREATMENT To be completed by Physician

- Has had an anaphylactic reaction in the past ____YES ____NO
- If yes, when and what where the symptoms _____
- Student Asthmatic ____YES* ____NO *High risk for severe reaction

Symptoms:

- ☐ If child exposed to allergen, but *no symptoms*
- ☐ Mouth: Itching, tingling, or swelling of lips, tongue, mouth
- ☐ Skin: Hives, itchy rash, swelling of the face or extremities
- ☐ Gut: Nausea, abdominal cramps, vomiting, diarrhea
- ☐ Throat: Tightening of throat, hoarseness, hacking cough
- ☐ Lung: Shortness of breath, repetitive coughing, wheezing
- ☐ Heart: Thready pulse, low blood pressure, fainting, pale blueness
- ☐ Other: _____
- ☐ If reaction is progressing (several of the above areas affected), give

Give Checked Medication:

- ____ Epinephrine ____ Antihistamine
- ____ Epinephrine ____ Antihistamine
- ____ Epinephrine ____ Antihistamine
- ____ Epinephrine ____ Antihistamine
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- ____ Epinephrine ____ Antihistamine

DOSAGE

Epinephrine: give _____ Medication /Dose /Route

Antihistamine: give _____ Medication /Dose /Route

Other: give _____ Medication /Dose /Route

____ This student is capable and has been instructed in the proper method of self-administering epinephrine using an autoinjector and may self-medicate.

____ This student may not self-medicate.

Physician Name: _____ Signature: _____ Date: _____

STEP 2: EMERGENCY CONTACTS To be completed by parent

1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor: _____ Phone Number: _____
3. Parent: _____ Phone Number: _____
4. Emergency Contacts - Name/Relationship and Phone Number(s)
 - a. _____
 - b. _____

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

Parent Name: _____ Signature: _____ Date: _____

