DEXTER COMMUNITY SCHOOLS

Allergy Action Plan

Student:_____ **DOB:** _____ **Grade:**_____ **Date:** _____

****PLEASE NOTE: Healthcare provider to complete remainder of this page except parent signature****

Allergy to:_____

Asthma: ☐ Yes ☐ No

ACTION FOR MINOR REACTION

1. If the only symptom(s) are: A few localized hives OR an itchy mouth, give **antihistamine** (see dose below)
2. Stay with student; call parents or emergency contacts.
3. Continue to observe student closely for changes, if symptoms progress or fail to improve, follow steps for **major reaction and Give Epinephrine.**

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
MOUTH	Itching or swelling of the lips, tongue or mouth
THROAT	Itchy throat, sensation of tightness, swelling, hoarseness, hacking cough
SKIN	Diffuse hives, itchy rash, redness, swelling about the face or extremities
STOMACH	Nausea, abdominal cramps, vomiting, diarrhea
LUNG	Shortness of breath, repetitive coughing, wheezing
HEART	Weak pulse, pale, dizzy, passing out

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation. ***Do not rely on antihistamine to treat a severe reaction****.*

ACTION FOR MAJOR REACTION

1. Inject epinephrine **IMMEDIATELY** in outer side of thigh.
2. **Call 911** and request an ambulance with epinephrine. Inform them that you have given epinephrine.
3. Give antihistamine (**if not vomiting**) and if not already taken.
4. Give inhaler if history of asthma and if available.
5. Stay with student at all times.
6. Lay child flat and raise legs. If vomiting or difficulty breathing, allow them to lay on their side or sit up.
7. If symptoms fail to improve or return, give another dose of epinephrine 5 minutes after the first dose.
8. Call parents or emergency contacts once Epinephrine has been given and 911 called.

MEDICATIONS/DOSES

Epinephrine Brand:_____ Epinephrine Dose: ☐ 0.3 mg ☐ 0.15 mg

Antihistamine:_____ Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

The student is capable of self-administering the above medications: **☐Yes** **☐No**

The student is capable of self-possessing the above medications: **☐Yes** **☐No**

_____ _____

Physician/Healthcare Provider Signature Date

I give my permission to Dexter Community Schools to distribute this plan to necessary school district staff and allow school staff to administer above medications according to the prescribing health care provider's orders AND school district policy.

_____ _____

Parent/Guardian Signature Date

Adapted from University of Michigan Hospitals and Health Centers Food Allergy Action Plan Division of Allergy & Clinical Immunology rev. 6/18/2025