Allergy Table ❑ Yes ❑ No
Bus ❑ Yes ❑ No

Northville Public Schools
School:_____

ALLERGY ACTION PLAN

Name: _____ Grade: _____

Allergy to: _____ School Year:_____

Weight: _____ lbs Asthma: ❑ Yes (higher risk for a severe reaction) ❑ No

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

− Call 911
− Begin monitoring (see below)

Additional medications:
− Antihistamine
− Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) →Use Epinephrine.

****When in doubt, use epinephrine. Symptoms can rapidly become more severe.****

MILD SYMPTOMS ONLY

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____
ANTIHISTAMINE (BRAND & DOSE in mg): _____
Other (e.g, inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the student. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given five minutes or more after the first if symptoms persist or recur. Treat student even if parents cannot be reached.

CONTACTS: Call Rescue Squad: 911

Parent/Guardian: _____ Phone: _____

Name/Relationship:_____ Phone: _____

Healthcare Provider Name: _____ Date:_____

Healthcare Provider Signature: _____Phone: _____

Required

Please provide at least two doses of epinephrine. Student should have one dose accessible **at all times** (not in backpack or locker). A back-up will be kept in the school office.

Parent/Guardian Signature: _____Date: _____