



ALLERGY ACTION PLAN – Requires PCP Signature

Student _____ DOB: _____ GR: _____

ALLERGY TO: _____

Asthmatic: YES * NO *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION – Systems: Symptoms:

- MOUTH: itching and swelling of the lips, tongue, or mouth
- THROAT*: itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN: hives, itchy rash, and/or swelling about the face or extremities
- GUT: nausea, abdominal cramps, vomiting and/or diarrhea
- LUNG*: shortness of breath, repetitive coughing and/or wheezing
- HEART*: “thread” pulse, “passing out”

The severity of the symptoms can quickly change. *All above symptoms can potentially progress to a life- threatening situation.

MEDICATIONS TO BE GIVEN (Antihistamine etc.)

Epinephrine 0.15mg/0.3mg Epinephrine IM to outer thigh (PCP Please circle)/Neffy 2mg/0.1ml nasal spray or Neffy 1mg/0.1ml nasal spray

1. NOTIFY: Parent/Guardian: _____

PCP SIGNATURE: _____ DATE: _____ STAMP _____

PARENT SIGNATURE: _____ DATE: _____

THEN CALL

1. 911
2. PARENT/GUARDIAN: _____ at _____
3. PCP: _____ at _____

DO NOT HESITATE TO CALL 911

School RN Signature: _____ Date: _____

Please turn over



TO BE COMPLETED FOR SELF- MEDICATION ONLY: (School trips, asthma inhalers, etc.)

_____ has been instructed in the proper use of this medication

_____ and is permitted to carry the medication on his/her person, or to keep same in his her locker or PE locker, as we consider him/her responsible for self-administration. This student is aware of the proper dosage, route of administration, appropriate time to administer, as well as signs or symptoms that indicate appropriate time to use.

Signature (Parent/Guardian)

Prescriber's Signature