For Clinic Office Use Only
Date:_____ Reviewed By: _____
Epinephrine Expiration: _____

Student's Name: _____

Summer 2026

Allergic Reaction Care Plan

DOB: _____ **Grade** (2026-2027)_____
Allergic to:_____
Asthma: Yes ☐ No ☐ **Previous Anaphylaxis**: Yes ☐ No ☐

Check symptoms student has had with past reactions:		
☐ Swelling of eyes, face, lips, throat, tongue	☐ Skin flushing or extreme paleness	☐ Rapid or weak pulse
☐ Red, raised rash anywhere on body	☐ Blueness around mouth	☐ Hoarseness
☐ Difficulty in breathing	☐ Absence of breathing	☐ Tightness in chest
☐ Itching with or without hives	☐ Abdominal pain	☐ Nausea
☐ Loss of consciousness	☐ Sense of impending disaster	☐ Vomiting
☐ Shortness of breath	☐ Difficulty in swallowing	☐ Dizziness
☐ Anxiety	☐ Fainting	☐ Other:

If above symptoms occur, the Student should be treated with the following without delay:

Treatment: Please check the appropriate boxes and sign below.

☐ Student is to carry Epipen/Twinject/Auvi-Q with backup in the Clinic.

☐ Student is not to carry Epipen/Twinject/Auvi-Q.

☐ Give Benadryl liquid. Check appropriate dose: ☐ 2.5MG ☐ 25MG ☐ 50MG

☐ Give epinephrine auto-injector (Epipen/ Twinject/Auvi-Q). Check appropriate dose: ☐ 0.15mg ☐ 0.30mg
A second dose of epinephrine may be given in 20 minutes if needed and available. ☐ Yes ☐ No

☐ **Call 911, then call parents listed below.**

☐ Other:

Parent/Guardian (call first)

Name_____

Phone_____

Parent/Guardian (call second)

Name_____

Phone_____

Emergency Contacts (contacted only if unable to reach both parents)

Name_____

Phone_____

Name_____

Phone_____

Parent Signature_____**Date**_____

Please return this form to:
eval@schenck.org.
282 Mt. Paran Road, NW, Atlanta, Georgia 30327 p.404-252-2591