SEVERE ALLERGY ACTION PLAN

Fairless Local Schools
2026-2027

Student's Name: _____ **Date of Birth:** _____
Grade: _____ **Home Room Teacher:** _____
Severe Allergy to: _____
Is Student Asthmatic? Yes ____ No ____ (If yes, student is higher risk for severe reaction)
Has EpiPen or Twinject? Yes ____ No ____ If yes, where kept at school? _____

♦ STEP 1: TREATMENT ♦

Symptoms		**Give Checked Medication** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*		_____ Epinephrine	_____ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	_____ Epinephrine	_____ Antihistamine
• Skin	Hives, itchy rash, swelling of face or extremities	_____ Epinephrine	_____ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	_____ Epinephrine	_____ Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough	_____ Epinephrine	_____ Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing	_____ Epinephrine	_____ Antihistamine
• Heart*	Thready pulse, low BP, fainting, pale, blueness	_____ Epinephrine	_____ Antihistamine
• Other*	_____	_____ Epinephrine	_____ Antihistamine
• If reaction is progressing (several of the above areas affected), give		_____ Epinephrine	_____ Antihistamine

*** are potentially life-threatening symptoms.**
The severity of symptoms can quickly change.

ALWAYS CALL 911 IF EPINEPHRINE IS ADMINISTERED!

DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg
(See reverse side for administration instructions)

Antihistamine: Give _____
Medication/Dose/Route

Other: Give _____
Medication/Dose/Route

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Emergency contacts. See attached Emergency Medical Form.

****Even if Parent/Guardian cannot be reached, do not hesitate to medicate and/or call 911.**

Special Instructions (to be completed by Physician): _____
_____
_____

_____ _____ _____
Physician's Signature (required) **Physician's Printed Name** **Date**

_____ _____
Physician's Address **Physician's Phone Number**

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____
Parent/Guardian Signature **Date**