Allergy Action Plan

Student's Name ______________________________ **D.O.B.** __________ **Teacher:** ______________

Place Child's Picture Here

ALLERGY TO: ____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆STEP 1: TREATMENT◆

Symptoms:

Give Checked Medication **:
(To be determined by physician authorizing treatment)

Symptoms		Give Checked Medication	
If exposed to an allergen, but no symptoms:		☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling or 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 blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other †	______________________	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give ____
medication/dose/route

Other: give: ____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS◆

1. Call 911 (or Rescue Squad: __________________) State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ______________________________ at ______________________________

3. Emergency contacts

Name/Relationship	Phone Number(s)	
a. ____________	1.) ____________	2.) ____________
b. ____________	1.) ____________	2.) ____________
c. ____________	1.) ____________	2.) ____________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Parent/Guardian Signature: ______________________________ Date: ____________

Doctor's Signature: ______________________________ Date: ____________
(Required)

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