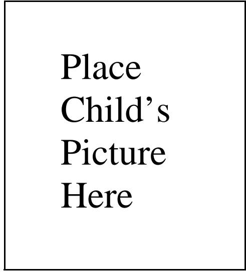
Allergy Action Plan



Student: ______________________________ **DOB** _________ **Teacher/Team:** __________

ALLERGY: ____

Asthmatic: ☐Yes* ☐No (*Higher risk for severe reaction)

♦ 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
• **Mouth**	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine
• **Skin**	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine
• **Gut**	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine
• **Throat†**	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine
• **Lung†**	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine
• **Heart†**	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine
• **Other†** ____________________________________		☐ Epinephrine
• **If reaction is progressing (several of the above areas affected), give:**		☐ Epinephrine

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

Dosage:

Antihistamine: ***To be administered by nurse only:** ____. **(Medication/dose/route)**

**In the event the nurse is not available, delegates should skip the antihistamine and give epinephrine* ____________*mg.*

Epinephrine: ☐**EpiPen®** ☐**EpiPen® Jr.** ☐**Twinject® 0.3 mg** ☐**Twinject® 0.15 mg** **(Inject Intramuscularly)**

☐ *This student has been trained and is capable of self administration of epinephrine single dose unit.*

Important: *Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.*

♦ 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. ____________________________________ Phone Number: ____

3. Parent____________________________________ Phone Number(s) ____

4. Emergency contacts: Name/Relationship Phone Number(s)

a. ____ 1.)____________________ 2.) ___________________

b. ____ 1.)____________________ 2.) ___________________

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

Parent/Guardian's Signature____ Date____________________

Physician's Signature____ Date____________________
(required)

Phone number: ______________________________ **Physician's Stamp:**