Allergy Action Plan

Students Name:_______________________________________ **D.O.B:**____________

ALLERGY TO:____

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

SYMPTOMS:	Give checked medication as determined by Physician:
If an exposure to the allergen has occurred, but there are NO symptoms:	☐Antihistamine ☐Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Antihistamine ☐Epinephrine
Skin: Hives, itchy rash, swelling of the face or extremities	☐Antihistamine ☐Epinephrine
♦Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Antihistamine ☐Epinephrine
♦Throat: Tightening of throat, hoarseness, hacking cough	☐Antihistamine ☐Epinephrine
♦Lung: Shortness of breath, repetitive coughing, wheezing	☐Antihistamine ☐Epinephrine
♦Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Antihistamine ☐Epinephrine
Other symptoms:	☐Antihistamine ☐Epinephrine
If reaction is progressing, several of the above areas affected:	☐Antihistamine ☐Epinephrine

♦Potentially life threatening. The severity of symptoms can quickly change.

DOSAGE:

Epinephrine: inject intramuscularly (see reverse side for instructions)

☐EpiPen® ☐EpiPen® Jr. ☐Twinject® 0.3 mg ☐Twinject® 0.15 mg

Antihistamine: ____

Medication/Dose/Route

Other:____

Medication/Dose/Route

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

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor:_______________________________ Phone Number:______________________
3. Parent:_______________________________ Phone Number:______________________
4. Other Emergency Contacts:

 Name:_______________________________ Phone Number:______________________

 Name:_______________________________ Phone Number:______________________

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

Parent/Guardians Signature:_______________________________ Date:______________

Physicians Signature:_____________________________________ Date:______________

Required