Allergy Action Plan

Place Child's Picture Here

Student's Name _____**D.O.B.** _____ **Teacher:** _____

ALLERGY TO: _____

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

◆STEP 1: TREATMENT ◆

Symptoms:	**Give Checked Medication **:** (To be determined by physician authorizing treatment)	
• 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 HESISTATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

(Required)