Allergy Action Plan

Place Child's Picture Here

Student's Name _____ DOB _____

Teacher's Name _____ Grade _____

ALLERGRY TO _____

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

STEP 1: TREATMENT

Symptoms		Give Checked Medications** (To be determined by physician authorized 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 the 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™ 0.3mg Twinject™ 0.15mg

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. _____ Phone _____

3. Emergency contacts:

Name/Relationship	Phone:	Cell:
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)