

ALLERGY ACTION PLAN

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 a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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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

**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. \_\_\_\_\_ 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)

