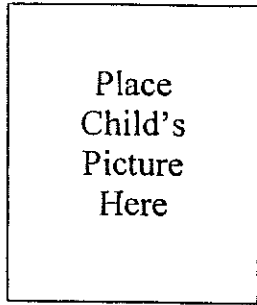


Allergy Action Plan

Student's

Name: _____ D.O.B: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>		<u>Give Checked Medication**:</u> **(To be determined by physician authorizing treatment)	
▪ If a food allergen has been ingested, but <i>no symptoms</i> :		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Skin Hives, itchy rash, swelling of the face or extremities		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Throat† Tightening of throat, hoarseness, hacking cough		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Lung† Shortness of breath, repetitive coughing, wheezing		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ Other† _____		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

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. _____ 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 _____

Doctor's Signature _____
(Required)

Date _____