Allergy Action Plan

Place child's picture here

Name: _____ DOB: _____ Teacher: _____

ALLERGY TO: _____

History of Anaphylaxis: Yes ☐ No ☐ If No, what type of reaction: _____

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

To be filled out by Physician: **Step 1: TREATMENT**

Symptoms:		**Give Checked Medication:**	
• If a food allergen has been ingested, but NO symptoms:		___ EpiPen	___ Antihistamine
• Mouth:	Itching, tingling OR swelling of lips/tongue/mouth	___ EpiPen	___ Antihistamine
• Skin:	Hives, itchy rash, swelling of face/extremities	___ EpiPen	___ Antihistamine
• Gut:	Nausea, abdominal cramps, vomiting, diarrhea	___ EpiPen	___ Antihistamine
• Throat:	Tightening of the throat, hoarseness, hacking cough	___ EpiPen	___ Antihistamine
• Lung:	Shortness of breath, repetitive coughing, wheezing	___ EpiPen	___ Antihistamine
• Heart:	Thready pulse, low blood pressure, fainting, pale, blueness	___ EpiPen	___ Antihistamine

The severity of symptoms can quickly change, give EpiPen immediately.

Dosage:

Epinephrine: Inject intramuscularly (check one): ___ Epinephrine 0.3mg ___ Epinephrine Jr. 0.15mg

Antihistamine: Give (Medication/dose/route) _____

Other: Give (Medication/dose/route) _____

To be filled out by Parent/Guardian: **Step 2: EMERGENCY CALLS**

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency Contacts:

Name:	Phone #s:
_____	1) _____ 2) _____
_____	1) _____ 2) _____

By signing this document, I, as the Parent/Guardian, give consent for the school nurse or any trained unlicensed personnel to administer epinephrine to my child.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____