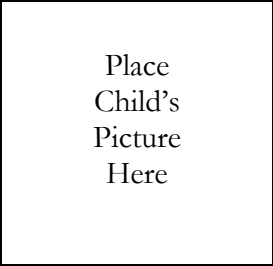


Allergy Action Plan

Student's Name: _____ DOB: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes No

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Circled Medication**:</u> <small>** (To be determined by physician authorizing treatment)</small>
◆ If a food allergen has been ingested, but <i>no symptoms:</i>	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* Weak or 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

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

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15mg

Other: _____
Medication/dose/route

Antihistamine: _____
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: State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent Name: _____ Phone Number(s) _____

4. Emergency Contacts:

Name/Relationship

Phone Number(s)

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 _____ Date: _____