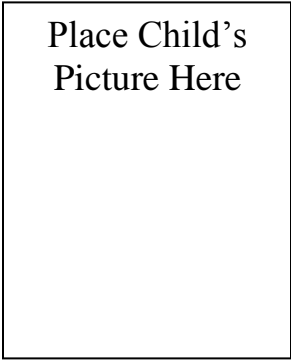


Allergy Action Plan



Student's Name: _____ D.O.B: _____

Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* ____ No ____ *Asthmatics are at higher risk for severe reaction

STEP 1: TREATMENT

<u>Symptoms:</u>	<u>Give Checked Medication**:</u>	
	<small>** (To be determined by physician authorizing treatment)</small>	
▪ 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 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

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: _____

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 _____