Place Child's Picture Here

ALLERGY ACTION PLAN

Student's Name:	Date of Birth:	Teacher:	Asthmatic: Yes or No

Step 1: TREATMENT

SYMPTOMS		Give Checked Medication	
If a food allergen has been ingested, but *no symptoms*		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 *	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

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

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, state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parents _____ Phone Number:_____
3. Dr. _____ Phone Number:_____at_____
4. Emergency Contacts 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 Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

(Required)