Allergy Action Plan

TO BE COMPLETED BY STUDENT'S PHYSICIAN

Student's
Name: _____DOB_____ Teacher/Grade_____

ALLERGY to:_____

Asthmatic **Yes*** ❑ **No** ❑ ***Higher risk for severe reaction**

Place Student' s Picture Here

◆**STEP 1: TREATMENT**◆ ****(To be determined by physician authorizing)**

Symptoms:	**Give Checked Medication**** (Dosage indicated below)	
• **IF allergen has been ingested/in contact, but NO symptoms**	❑**Epinephrine**	❑**Antihistamine**
• **Mouth Itching, tingling, 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, blue**	❑**Epinephrine**	❑**Antihistamine**
• **Other** _____	❑**Epinephrine**	❑**Antihistamine**
• **IF reaction is progressing(several of above affected) GIVE**	❑**Epinephrine**	❑**Antihistamine**

Note: Severity of symptoms can quickly change

Dosage

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen®Jr Other_____

Antihistamine: _____
Medication/Dose/Route

Other:_____
Medication/Dose/Route

Important: Asthma inhalers and /or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆STEP 2: Emergency Calls◆ **(Print Clearly)……Contact information to be completed by parent/guardian**

1. **Call 911** (and Health professional if available) State that an allergic reaction has been treated, and epinephrine **or** additional epinephrine may be needed.
2. Parent/Guardian: Home: Cell:
3. Alternate contact: Home: Cell:
4. Alternate contact: Home: Cell:
5. Alternate contact: Home: Cell:

IF Parent/Guardian CANNOT be reached, do not hesitate to medicate or transport by ambulance to hospital!

Physician Signature: _____**Date**_____
Required

Print Physician Name: _____**Phone:**_____

Parent/Guardian Signature:_____**Date:**_____

This Allergy Action Plan will be shared with school staff who need to know.