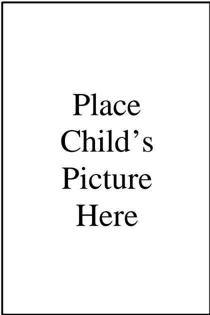
Allergy Action Plan



Student's Name ______________________________**D.O.B.** ___________ **Teacher:** _______________

ALLERGY TO: ____

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

◆STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication **:** (To be determined by physician authorizing treatment)	
• If exposed to an allergen, but no symptoms:		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling or 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 (see reverse side for instructions)

Antihistamine: give ____
medication/dose/route

Other: give: ____
medication/dose/route

◆ 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. ______________________________ at ______________________________

3. Emergency contacts

Name/Relationship	Phone Number(s)	
a. ______________________	1.) ______________________	2.) ______________________
b. ______________________	1.) ______________________	2.) ______________________
c. ______________________	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)