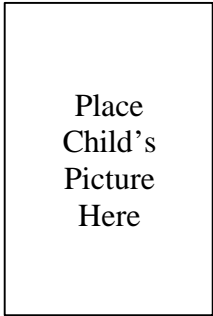


Allergy Action Plan



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: | <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 or 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 [†] 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 |

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)