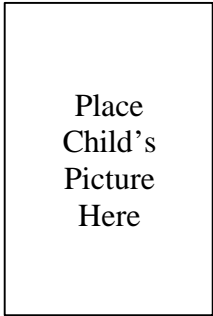


# Allergy Action Plan



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 <sup>†</sup> Tightening of throat, hoarseness, hacking cough            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung <sup>†</sup> Shortness of breath, repetitive coughing, wheezing           | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart <sup>†</sup> Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other <sup>†</sup> _____   | <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. <sup>†</sup> 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)