Allergy Action Plan

Place picture here

Student Name:_____**D.O.B:**_____**Teacher:**_____

ALLERGY TO:_____
Asthmatic ☐No ☐Yes* *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give Checked Medication:
(to be checked by prescribing physician)

- If an allergen has been ingested, but *no symptoms* ☐ EpiPen ☐Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth ☐ EpiPen ☐Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities ☐ EpiPen ☐Antihistamine
- Gut Nausea, abdominal cramps, vomiting, diarrhea ☐ EpiPen ☐Antihistamine
- Throat** Tightening of throat, hoarseness, hacking cough ☐ EpiPen ☐Antihistamine
- Lung** Shortness of breath, repetitive coughing, wheezing ☐ EpiPen ☐Antihistamine
- Heart** Thready pulse, low blood pressure, fainting, pale, blueness ☐ EpiPen ☐Antihistamine
- Other** _____ ☐ EpiPen ☐Antihistamine
- If reaction is progressing (several of the above areas affected), give ☐ EpiPen ☐Antihistamine

The severity of symptoms can quickly change. ☛☛ Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (**circle one**) EpiPen® 0.3mg, EpiPen Jr® 0.15mg, Twinject® 0.3mg, Twinject® 0.15mg (see reverse side for instructions)

Antihistamine:

_____
medication/dose/route

***AVOID MOVING THE VICTIM: CALMING REDUCES THE DISTRIBUTION OF THE ALLERGEN IN THE BODY**.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad: _____) State that an allergic reaction has been treated, and additional epinephrine may be needed)

Dr. _____ at _____

Emergency contacts: Names **Phone numbers**

_____ 1.)_____ 2.) _____

_____ 1.)_____ 2.) _____

_____ 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)