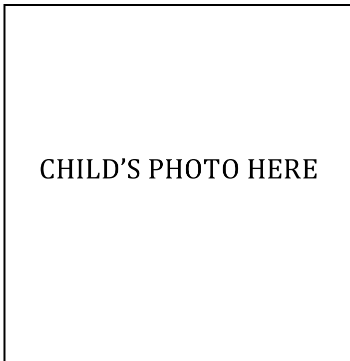

Allergy Action Plan

TREATMENT

Student's name: ___________________________ **D.O.B:**______________**Class:**________________________

Allergy to:____

Asthmatic? Yes ☐ **No** ☐

Symptoms:	**Circle Correct Medication:***
1. If a food allergen has been ingested, but *no symptoms:*	1. Epinephrine Antihistamine
2. Mouth: itching, tingling, or swelling of lips, tongue, mouth	2. Epinephrine Antihistamine
3. Skin: hives, itchy rash, swelling of the face extremities	3. Epinephrine Antihistamine
4. Gut: nausea, abdominal cramps, vomiting, diarrhea	4. Epinephrine Antihistamine
5. Throat: tightening of throat, hoarseness, hacking cough	5. Epinephrine Antihistamine
6. Lung: shortness of breath, repetitive coughing, wheezing	6. Epinephrine Antihistamine
7. Heart: thread pulse, low blood pressure, fainting, pale, blueness	7. Epinephrine Antihistamine
8. Other:____________________________________	8. Epinephrine Antihistamine
9. If reaction is progressing (several of the above areas affected) give:	9. Epinephrine Antihistamine

*To be determined by physician authorizing treatment

DOSAGE

Epinephrine: inject intramuscularly (circle one):

EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg Other:_______________

Antihistamine: give____
Medication/dose/route

Other: give____
Medication/dose/route

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

EMERGENCY CALLS

Emergency Contacts

Name/Relationship: Phone Number/s:

1) ________________________________ ________________________________

2) ________________________________ ________________________________

3) ________________________________ ________________________________

Doctor Information

Dr. ________________________________ @________________________________

EVEN IF CAREGIVER CANNOT BE REACHED, DO NOT HESITATE TO FOLLOW THE TREATMENT OUTLINED ABOVE, CALL 911, OR TAKE CHILD TO MEDICAL FACILITY IF NECESSARY.

Caregiver Signature________________________________ Date______________