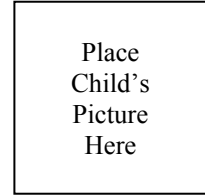


Allergy Action Plan

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 provider authorizing treatment)

- | | | | | | | | | | | | | | | | | | |
|---|---|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|
| <ul style="list-style-type: none">▪ If food allergen has been ingested or allergen has been contacted, but <i>no symptoms</i>:▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth▪ Skin Hives, itchy rash, swelling of the face or extremities▪ Gut Nausea, abdominal cramps, vomiting, diarrhea▪ Throat† Tightening of throat, hoarseness, hacking cough▪ Lung† Shortness of breath, repetitive coughing, wheezing▪ Heart† Thready pulse, low blood pressure, fainting, pale, blueness▪ Other† _____▪ If reaction is progressing (several of the above areas affected), give | <table border="0" style="width: 100%;"><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr><tr><td><input type="checkbox"/> Epinephrine</td><td><input type="checkbox"/> Antihistamine</td></tr></table> | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <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)

Student can self carry medication? Yes No Student can self-administer medication? Yes No

Epinephrine is stored: In Health Room Student carries medication Other _____

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

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

◆STEP 2: EMERGENCY CALLS◆

1. Call 911 (or Emergency Medical Services _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Provider: _____ 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 _____

Provider Signature _____ Date _____