ALLERGY ACTION PLAN

Student's Name _____ Date of Birth _____ Grade _____

Allergy to: _____

Asthmatic _____ No _____ Yes * *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		Give Checked Medication**:
		** To be determined by physician authorizing treatment
If a food allergen has been ingested, but *no symptoms:*		☐ Epinephrine ☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
Throat †	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
Heart †	Weak or thread pulse, low BP, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
Other †	_____	
If reaction is progressing (several of the above areas affected) give:		☐ Epinephrine ☐ Antihistamine

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

Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3mg Twinject® 0.15mg

Antihistamine: give _____

Student has permission to self-carry: _____ Yes _____No

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

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number _____
3. Parent _____ Phone Number(s) _____
4. Emergency Contact:

   Name_____Relationship_____Phone Number_____

I give permission for the staff at CCS to have access to this information _____Yes _____No

Parent/Guardian Signature _____ Date _____

Doctor's Signature (required) _____ Date _____

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