

## ALLERGY ACTION PLAN

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic:  Yes\*  No \* Higher risk for severe reaction



### Treatment

To be determined by healthcare provider authorizing treatment

Location	Symptoms	Give Checked Medication	
If an allergen has been suspected but no symptoms are present			
		<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 of 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 †	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other † _____		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above affected areas)		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

### Dosage

**Epinephrine:** inject intramuscularly  EpiPen  EpiPen Jr.  Twinject 0.3 mg  Twinject 0.15 mg

Where Stored:  Clinic  Student's Bookbag  Student's Locker (# \_\_\_\_\_)  Other \_\_\_\_\_

**Antihistamine:** give \_\_\_\_\_  
(medication/dose/route)

Where Stored:  Clinic  Student's Bookbag  Student's Locker (# \_\_\_\_\_)  Other \_\_\_\_\_

**Other:** give \_\_\_\_\_  
(medication/dose/route)

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

### Emergency Calls

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call Dr. \_\_\_\_\_ at \_\_\_\_\_
3. Call Emergency Contacts

Name/Relationship	Primary Contact Number	Secondary Contact Number
A)		
B)		
C)		

This Allergy Action Plan has been approved by:

Healthcare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider's Address: \_\_\_\_\_

Healthcare Provider's Phone #: \_\_\_\_\_ Healthcare Provider's Phone #: \_\_\_\_\_

I give permission to the school nurse and other trained staff members of the \_\_\_\_\_ School District to perform and carry out tasks as outlined in this allergy action plan. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need this information to maintain my child's health and safety while at school.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### TO BE COMPLETED BY THE SCHOOL

#### Allergic Reaction Response

Location	Response
Classroom	
Lunchroom	
Parties	
Field Trips	
Other: _____	

#### Personnel Trained to Follow Response and Administer Medication

Names	Room/Bus Number	Date Trained
Classroom Teacher(s):		
Office Personnel:		
School Nurse(s):		
Administrator(s):		
Lunchroom Staff:		
Bus Driver(s):		
Other:		