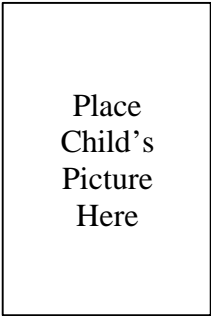


Allergy Action Plan



Student's Name _____ D.O.B. _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If exposed to an allergen, but no symptoms:
- Mouth Itching, tingling or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling or 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

Give Checked Medication **:

(To be determined by physician authorizing treatment)

- | | |
|--------------------------------------|--|
| <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 |
| <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)

Antihistamine: give _____ medication/dose/route

Other: give: _____ medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

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

2. Dr. _____ 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: _____

Doctor's Signature: _____ Date: _____

(Required)