Emergency 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 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†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
➢ Other†	______________________________	☐ Epinephrine	☐ Antihistamine
➢ If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

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

DOSAGE

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

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 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!

☐ It is my professional opinion that this student should be allowed to carry and use this medication.

☐ In my professional opinion, this student **should not** carry this medication and it should be stored in the health office.

Parent/Guardian Signature: ______________________________ Date: ______________

Doctor's Signature: ______________________________ Date: ______________
(Required)