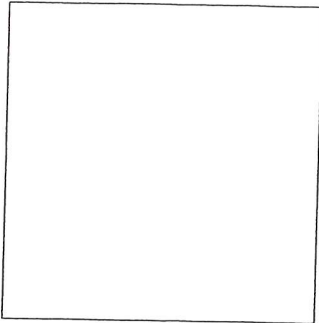


ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN



Student _____ School _____
 DOB _____ Teacher/Grade _____

Allergy to _____
 Asthmatic? Yes* No *Higher risk for severe reaction

STEP 1 - TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

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

Symptoms

- ◆ If a student has been exposed to/ingested an allergen but has NO symptoms:
- ◆ 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:

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 |
| <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 |

MEDICATION: START DATE _____ END DATE _____

Epinephrine: Inject intramuscularly.

Important; Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.

Epinephrine Autoinjector 0.3mg

Epinephrine Autoinjector 0.15mg

Antihistamine: Give _____
antihistamine dose route

Other: Give _____
medication dose route

Parent/Guardian Signature _____ Date _____

Prescriber Name _____ Phone _____

Prescriber Signature _____ Date _____

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.
 Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student. Contact Parent/Guardian.

EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDICATE CHILD & CALL 911

EMERGENCY CONTACTS

Name	Relationship	Telephone number
1. _____	_____	_____
2. _____	_____	_____

**** Form on Page 2 to be completed ONLY if student will be carrying an Epinephrine Autoinjector ****