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ALLERGY ACTION PLAN

Date: ______________________________
School Year: _________________________
Teacher/Grade: _____________________

Student: ____ DOB: ______________________

Allergy:____

Action Plan-Parent/Guardian is responsible for all medications & supplies
Symptoms:

Symptoms	Epinephrine	Antihistamine
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
Stomach- Nausea, abdominial cramps, vomiting, diarrhea	____Epinephrine	____ Antihistamine
Throat*- Tightening of throat, hoarseness, hacking cough	____Epinephrine	____ Antihistamine
Lung*- Shorteness 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 are affected	____Epinephrine	____ Antihistamine

*Potentially life threatening, the severity of symptoms can quickly change

Dosage:
Antihistamine: give ____
Medication/dose/route
Other: give ____
Medication/dose/route

If symptoms do not improve in __________ minutes:
_______ Repeat medications above
_______ Administer Epinephrine: inject intramuscularly (circle one) Epi Pen   Epi Pen Jr. Twinject 0.3mg Twinject 0.15mg
_______ Call EMS
_______ Contact parent/guardian for further instructions

Any other pertinent information regarding your child’s allergies: ____
____
____

Physician’s Signature: ___________________________________ Date: _______________ Phone: __________

Parent/Guardian: _____________________________________ Date: _______________ Phone: ___________

*Teachers will be notified of your child’s allergy on a need to know basis