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:

MEDICATION:  START DATE _______________  END DATE _______________
Epinephrine: Inject intramuscularly.

☐ 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

1. ____________________________   Relationship ____________________________   Telephone number ____________________________

2. ____________________________   Relationship ____________________________   Telephone number ____________________________

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