Allergy Action Plan

Child's Name _____ D.O.B._____ Teachers _____

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:

• 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™ 0.3 mg. Twinject™ 0.15 mg.
(see reverse side for further 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 Numbers
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_____

FURTHER EPINEPHRINE INSTRUCTIONS: