CHILD'S LAST NAME, FIRST NAME:

THE CHILDREN'S CIRCLE PRESCHOOL

ALLERGY ACTION PLAN

Child's Name ______________________________ DOB_______________ 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_________________________

CHILD'S LAST NAME, FIRST NAME:

FURTHER EPINEPHRINE INSTRUCTIONS: