ALLERGY ACTION PLAN

Student's Name:________________________D.O.B:________Teachers/Grade:______________Bus #___

ALLERGY TO:____

Asthmatic Yes* ☐ No ☐ ***Higher risk for severe reaction**

♦ STEP 1: TREATMENT ♦

Symptoms:		**Give Checked Medication****	
▪ If exposed to allergen, but *no symptoms*:		☐ Epi-Pen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epi-Pen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epi-Pen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epi-Pen	☐ Antihistamine
▪ Throat+	Tightening of throat, hoarseness, hacking cough	☐ Epi-Pen	☐ Antihistamine
▪ Lung+	Shortness of breath, repetitive coughing, wheezing	☐ Epi-Pen	☐ Antihistamine
▪ Heart+	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epi-Pen	☐ Antihistamine
▪ Other +	____	☐ Epi-Pen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ Epi-Pen	☐ Antihistamine

The severity of symptoms can quickly change. ***+ Potentially life-threatening.***

MEDICATIONS: Provided by parent/guardian to be kept at school. ***See Medication Form***

☐ **Epinephrine:** inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

☐ **Antihistamine:** give____

☐ **Other:** give ____

♦ 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. Emergency contacts:

Name/Relationship Phone Number(s)

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!

3. Dr. _____________________________ at ____________________________________

Parent/Guardian Signature____ Date________________

Cc: School Faculty (Principal, Assistant Principal, Secretary, Office Aide, Classroom/PE/Art/Music Teachers, Cafeteria Mgr, DARE Officer, Guidance Counselor, Librarian, School Health File, School Health Nurse, Bus Driver

EPIPEN® AND EPIPEN® JR. DIRECTIONS

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh)**

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- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds. Record time given.**

- **Once EpiPen® is used, call the Rescue Squad. State additional epinephrine may be needed. Give the used unit with you to the Emergency Personnel.**

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*