ALLERGY ACTION PLAN

Place Child's Pictures Here

Student's
Name: _____ D.O.B. _____ Gender: _____

Parent/Guardian: _____ Grade: _____ Teacher: _____

ALLERGY TO: _____

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

Treatment

To be determined by healthcare provider authorizing treatment

Location	Symptoms	Give Checked Medication
If an allergen has been suspected but no symptoms are present		☐ Epinephrine ☐ Antihistamine
Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
Skin	Hives, itchy rash , swelling of 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 affected areas)		☐ Epinephrine ☐ Antihistamine

Note: The severity of symptoms can change quickly. † Potentially life-threatening

Dosage

Epinephrine: inject intramuscularly ☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3 mg ☐ Twinject 0.15 mg
Where Stored: ☐ Clinic ☐ Student's Bookbag ☐ Student's Locker (# _____) ☐ Other _____

Antihistamine: give _____
(medication/dose/route)
Where Stored: ☐ Clinic ☐ Student's Bookbag ☐ Student's Locker (#_____) ☐ Other _____

Other: give _____
(medication/dose/route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis

Emergency Calls

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call Dr. _____at _____
3. Call Emergency Contacts

Name/Relationship	Primary Contact Number	Secondary Contact Number
A)		
B)		
C)		

This Allergy Action Plan has been approved by:

Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Address: _____

Healthcare Provider's Phone #: _____ Healthcare Provider's Phone #: _____

I give permission to the school nurse and other trained staff members of the _____ School District to perform and carry out tasks as outlined in this allergy action plan. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need this information to maintain my child's health and safety while at school.

Parent/Guardian's Signature: _____ Date: _____

TO BE COMPLETED BY THE SCHOOL

Allergic Reaction Response

Location	Response
Classroom	
Lunchroom	
Parties	
Field Trips	
Other: _____	

Personnel Trained to Follow Response and Administer Medication

Names	Room/Bus Number	Date Trained
Classroom Teacher(s):		
Office Personnel:		
School Nurse(s):		
Administrator(s):		
Lunchroom Staff:		
Bus Driver(s):		
Other:		