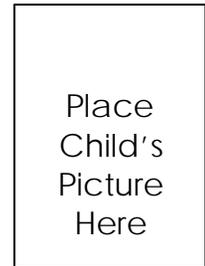


# Allergy Action Plan

(NEED ONLY BE COMPLETED IF YOUR CHILD HAS ALLERGIES)

# Form E

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Grade: \_\_\_\_\_



ALLERGY TO (list all) : \_\_\_\_\_

Asthma: Yes\*  No  \*Higher risk for severe reaction

## STEP 1: TREATMENT

### Symptoms:

- If exposed to allergen, but *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

### Give Checked Medication :

- EpiPen  Antihistamine

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

### DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen EpiPen Jr.

**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 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!**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_