



PLACE STUDENT'S
PICTURE HERE

Allergy Action Plan

1. ONLY if your student has severe allergic reactions, complete the Allergy Action Plan Form. This form gives specific instructions about what to do if your child has an allergic reaction. You will need a recent photo of your child to attach to the form.

2. Provide all medication and instructions for use in the original medication box or fanny pack that is clearly labeled with your child's name. Be sure to check the expiration dates and replace medications as needed.

3. Students with food allergies: Provide a box of "safe snacks" so there is always something for your child to choose from during unplanned special events or special occasions. Please label your child's name on the outside of the box.

Student's Name _____ DOB _____ Teacher _____

Foods and ingredients your child needs to avoid _____

Other allergies _____

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

STEP I: TREATMENT

Symptoms	Give Checked Medicine (To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but no symptoms	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth-Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin-Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut-Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat 🚩 -Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung 🚩 -Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart 🚩 -Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other 🚩 _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

🚩 Potentially life-threatening. The severity of symptoms can quickly change. Seek immediate medical attention.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: Medication/Dose/Route _____

Other: Medication/Dose/Route _____

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

STEP 2: EMERGENCY CALLS

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

Student's Physician _____ Phone Number _____

Parent(s) _____ Phone Number _____

Emergency Contacts:

Name/Relationship _____ Phone #1 _____ Phone #2 _____

Name/Relationship _____ Phone #1 _____ Phone #2 _____

Name/Relationship _____ Phone #1 _____ Phone #2 _____

Even if a parent/guardian cannot be reached, DO NOT HESITATE to medicate or take student to medical facility!

Signature of Parent/Guardian

Date