

Life-Threatening Allergy Action Plan



Student's Name: _____ Date of Birth: _____
Last, First Month/Date/Year

ALLERGY TO: _____
 Asthmatic: YES * NO * Higher risk for sever reaction

◆ **STEP 1: TREATMENT** ◆

To be determined by physician authorizing treatment

SYMPTOMS:

The severity of symptoms can quickly change.

- If a food allergen has been ingested, 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)

† Potentially life-threatening.

GIVE CHECKED MEDICATION:

- | | |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

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 Contact Phone Number(s)

1. _____ 1. _____ 2. _____

2. _____ 1. _____ 2. _____

3. _____ 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 (Required)

 Date