Allergy Action Plan

Name:_____ Grade: _____ D.O.B: ____/_____/_____

Allergy to: _____(circle all that apply) **ingestion**/inhaled/**contact**/testing

Age when first diagnosed_____ Date of most recent reaction_____ Describe reaction(s) and treatment given _____.

Weight: _____ Asthma: YES___ (higher risk for severe reaction) NO_____

Any **SEVERE SYMPTOMS** after suspected or known ingestion:

One or More of the following:

LUNG	Short of breath, wheeze, repetitive cough
HEART	Pale, blue, faint, weak pulse, dizzy, confused
THROAT	Tight, hoarse, trouble breathing/swallowing
MOUTH	Obstructive swelling of tongue and/or lips
SKIN	Many hives over body

Or **combination of symptoms** involving different body areas:

SKIN	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT	Vomiting, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Stay with student, alert health-care professionals and Parent.
4. Give additional medications
   - Antihistamine
   - Inhaler if Asthmatic

MILD SYMPTOMS ONLY:

MOUTH	Itchy mouth
SKIN	A few hives around mouth/face, mild itch
GUT	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert health-care professionals and Parent.
3. If symptoms progress (see above) **USE EPINEPHRINE** and call 911.

MEDICATIONS/ DOSAGE:

Epinephrine: (circle one) Epi-Pen or Epi-Pen Jr To be administered into outer thigh-through clothing

Antihistamine: medication _____dosage_____

Inhaler: (if asthmatic) medication _____dosage_____

DO NOT HESITATE TO MEDICATE – WHEN IN DOUBT GIVE EPI-PEN and call 911 and School Nurse @ x6017 or x7517 or use channel 1 on radio

*Epi-Pens are **required** to kept in the health room for all students in lower, middle *and* upper school. Athletes in middle and upper school will also be **required** to provide and Epi-Pen to their respective athletic trainer.

Please check all locations in which your child will have and Epi-Pen: ___Health Room ___Health Room and Carried by student ___MS or US Athletic Trainer ___Extended Day ___other:_____.

EMERGENCY CONTACTS:

1. Name/Relationship_____ phone #1_____ #2_____
2. Name/Relationship_____ phone #1_____ #2_____

PARENT/GUARDIAN SIGNATURE _____Date: _____

PHYSICIAN SIGNATURE _____Date: _____