SEVERE ALLERGY OR ANAPHYLAXIS ACTION PLAN

Place Child's Picture Here

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

ALLERGY TO: _____

Asthmatic : Yes _____ No_____ * Higher risk for severe reaction

****STEP 1: TREATMENT****			
Symptoms:		**Give checked medication*** *(TO BE DETERMINED BY PHYSICIAN AUTHORIZING TREATMENT)*	
If exposed but no symptoms:			☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the 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+	Weak or thready pulse, low blood pressure, fainting, pale, blueness.	☐ Epinephrine	☐ Antihistamine
Other+	_____	☐ Epinephrine	☐ Antihistamine

+ Potentially Life Threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) Epi-Pen 0.3mg., Epi-Pen Jr.0.15mg.,Twinject 0.3mg., Twinject 0.15mg Auvi Q

ONCE INJECTED YOU MUST HOLD EPI-PEN IN PLACE FOR 10 SECONDS!!

Antihistamine: give_____
Medication/dose/route

Other: give _____
Medication/dose/route

IMPORTANT: IF EPINEPHRINE IS ADMINISTERED YOU MUST CALL 911!!

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._____ Phone # _____
3. Parent_____ H#_____ C#_____ W#_____
   Parent_____ H#_____ C#_____ W#_____
4. Emergency contacts : Name/ Relationship Phone #s:

a._____ H#_____ C#_____ W#_____
b._____ H#_____ C#_____ W#_____

Even if Parent /guardian cannot be reached, do not hesitate to medicate or take child to medical facility!

Parent/Guardian's Signature_____ **Date**_____
Doctor's Signature _____ **Date**_____
(Required)

Physician's Name/Stamp/Phone#_____