Allergy Action Plan

For School Year ____________________

Student's Name: ____________________________________ DOB ________ Grade _______

ALLERGY TO: ____

Asthmatic: Yes*[ ] No [ ] *Higher risk for severe reaction

❖ STEP 1 TREATMENT

Symptoms:	Give checked medication To be determined by physician authorizing	
• If food allergen has been ingested, but no symptoms:	[ ] EpiPen	[ ]Antihistamine
• Mouth – Itching, tingling, or swelling lips, tongue, mouth	[ ] EpiPen	[ ] Antihistamine
• Skin – Hives, itchy rash, swelling of the face or extremities	[ ] EpiPen	[ ] Antihistamine
• Gut – Nausea, abdominal cramps, vomiting, diarrhea	[ ] EpiPen	[ ] Antihistamine
• Throat* - Tightening of throat, hoarseness, hacking cough	[ ] EpiPen	[ ] Antihistamine
• Lung* - Shortness of breath, repetitive coughing, wheezing	[ ] EpiPen	[ ] Antihistamine
• Heart* - Thready pulse, low B/P, pale, blueness	[ ] EpiPen	[ ] Antihistamine
• Other* ______________________________	[ ] EpiPen	[ ] Antihistamine
• If reaction is progressing or several of the above reactions	[ ] EpiPen	[ ] Antihistamine

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

DOSAGE: EPIPEN EPIPEN JR Twinjet 0.3mg Twinjet 0.15mg

Antihistamine: give ____
Medication/dose/route

Other: ____

❖ STEP 2 EMERGENCY CALLS

1. Call 911 – all students must go to Emergency Room after use of EpiPen
2. Dr. _______________________ at ______________________________
3. Parents Phone numbers

Parents	Phone numbers	
__________________	1. __________________	2. __________________
__________________	1. __________________	2. __________________

Physician Signature: ______________________________ Stamp:

Date: ____