Severe Allergy Action Plan

Student's Name ______________________ D.O.B.__________ Teacher ______________________

ALLERGY TO: ____

STEP 1: TREATMENT

Symptoms:		Give Checked Medication **(To be determined by physician authorizing treatment)	
❑ 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†	Thready pulse, low blood pressure, fainting, pale, blueness	❑ Epinephrine	❑ Antihistamine
❑ Other†	______________________	❑ Epinephrine	❑ Antihistamine
❑ If reaction is progressing (several of the above areas affected), give		❑ Epinephrine	❑ Antihistamine

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

DOSAGE

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

Antihistamine: give ____
medication/dose/route

Other: give ____
medication/dose/route

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

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 Number: ________________

3. Parents ______________________________ Phone Number(s) ________________

4. Emergency contacts:
Name/Relationship Phone Number(s)
a. ______________________________ (1) ________________ (2) ________________

b. ______________________________ (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 ______________________________ Date ________________
(Required)