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)