·ALLERGY ACTION PLAN·

STUDENT'S NAME: _____

D.O.B: _____

ALLERGIC TO: _____

SCHOOL: _____

GRADE/TEACHER: _____

ASTHMATIC? NO / *YES (*AT HIGHER RISK FOR LIFE THREATENING REACTION)

BUS RIDER? NO / YES _____

DATE & SYMPTOMS OF LAST REACTION: _____

PLACE CHILD'S PHOTO HERE

LOCATION OF EPI PEN/MED: __STUDENT __BACKPACK __ CLINIC___CLASSROOM ___OTHER:_____

SIGNS OF AN ALLERGIC REACTION

MOUTH:
- Tingling
- Itching
- Swelling of lips
- Swelling of tongue

THROAT:
- Tightening of throat
- Hoarseness
- Hacking cough

SKIN:
- Hives
- Itching, Rash
- Swelling of face
- Swelling of limbs

STOMACH:
- Nausea
- Vomiting
- Diarrhea
- Cramps

LUNG:
- Shortness of breath
- Wheezing
- Repetitive cough

HEART:
- Weak pulse
- Fainting
- Pale

• IF KNOW ALLERGEN HAS BEEN INGESTED, BUT NO SYMPTOMS:

_____

ACTION FOR MAJOR REACTION

IF SYMPTOMS ARE: _____

1. **IMMEDIATELY ADMINISTER EPINEPHRINE:** _____
   ADMINISTER ANTIHISTAMINE: _____
   MEDICINE/DOSE
2. **CALL 911** Request rescue squad, additional epinephrine & immediate transport to hospital
3. **NOTIFY PARENTS**

ACTION FOR MINOR REACTION

IF SYMPTOMS ARE: _____

ADMINISTER: _____
MEDICINE/DOSE:

EMERGENCY CONTACT NUMBERS

NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE ( )	CELL ( )
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PARENT'S/GUARDIAN'S SIGNATURE/DATE: _____

PHYSICIAN'S SIGNATURE/DATE: _____