



# • 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: \_\_\_\_\_

**2** ADMINISTER ANTIHISTAMINE: \_\_\_\_\_

**2** CALL 911 Request rescue squad, additional epinephrine & immediate transport to hospital

MEDICINE/DOSE

**3** NOTIFY PARENTS

## ACTION FOR MINOR REACTION

IF SYMPTOMS ARE: \_\_\_\_\_

ADMINISTER: \_\_\_\_\_

MEDICINE/DOSE:

## EMERGENCY CONTACT NUMBERS

		( )	( )
NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE	CELL
		( )	( )
NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE	CELL
		( )	( )
NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE	CELL

PARENT'S/GUARDIAN'S SIGNATURE/DATE: \_\_\_\_\_