## Allergy & Anaphylaxis Action Plan

Student's Name: _____ D.O.B. _____ Grade: _____
School: _____ Teacher: _____

Place child's photo here

ALLERGY TO: _____
History: _____

Asthma: ☐YES (Higher risk for severe reaction) ☐NO

### ◊ STEP 1: TREATMENT

| SYMPTOMS: GIVE CHECKED MEDICATION(S): | | |
|---|---|---|
| ➢Suspected ingestion or sting, but *no symptoms* | ☐Epinephrine | ☐Antihistamine |
| MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort | | ☐Antihistamine |
| MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth | ☐Epinephrine | ☐Antihistamine |
| SKIN: Flushing, hives, itchy rash | ☐Epinephrine | ☐Antihistamine |
| STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea | ☐Epinephrine | ☐Antihistamine |
| ‡ THROAT Tightening of throat, hoarseness, hacking cough | ☐Epinephrine | ☐Antihistamine |
| ‡ LUNG Shortness of breath, repetitive coughing, wheezing ☐ Inhaler | ☐Epinephrine | ☐Antihistamine |
| ‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin | ☐Epinephrine | ☐Antihistamine |
| ➢If reaction is progressing (several of the above areas affected), give | ☐Epinephrine | ☐Antihistamine |

‡ Potentially life threatening: give epinephrine **first**, then can give antihistamine!
Remember - severity of symptoms can quickly change!

**DOSAGE**

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ 0.3 mg ☐ 0.15 mg
☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give _____
(medication/dose/route)

Asthma Rescue (if asthmatic): give _____
(medication/dose/route)

Student has been instructed and is capable of self administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

### ◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____