



ALLERGY EMERGENCY ACTION PLAN

Student's Last Name Student's First Name MI Sex Date of Birth Grade

Allergy To: _____

In case of severe allergic reaction, please contact: _____ Phone _____

TO BE COMPLETED BY THE PHYSICIAN (Note to physician: Please be detailed. School personnel will use this information for directions in an acute situation.)

SYMPTOMS

If contact has been made with an allergen, but *no symptoms*

Mouth: Itching, tingling or swelling of lips, tongue, mouth

Skin: Hives, itchy rash, swelling of the face or extremities

Gut: Nausea, abdominal cramps, vomiting, diarrhea

Throat*: Tightening of throat, hoarseness, hacking cough

Lung*: Shortness of breath, repetitive coughing, wheezing

Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness

Other*: _____

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

GIVE CHECKED MEDICATION

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

DOSAGE

Epinephrine: Inject intramuscularly (circle one):

EpiPen® EpiPen® Jr. Twinject® 0.15 mg Adrenaclick™ 0.3 mg Adrenaclick™ 0.15 mg

Antihistamine: Give (medication/dosage/route): _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Call Parent/Guardian/Emergency Contact (noted above)

Call 9-1-1. State that an allergic reaction has been treated, and additional epinephrine may be needed.

Name of Medication Given: _____ Amount _____

Time Given: _____ Signature of Giver: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Physician Name (Printed) _____

Physician's Signature _____ Date _____

Parent/Guardian's Signature(s) _____ Date _____