



Allergy Action Plan
Emergency Care Plan

Place
Student's
Picture
Here

Name: _____ D.O.B. _____

Allergy to: _____

Student ID: _____ Asthma: Yes (higher risk for a severe reaction) No

Extremely reactive to the following: _____

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if likely exposed to the allergen.

If checked, give epinephrine immediately if the allergen was *definitely* exposed, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body

Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, diarrhea, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Monitor student.
4. Give additional medications if ordered. *
5. Notify parent.

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; notify parent.
3. If symptoms progress (see above), USE EPINEPHRINE.
4. Monitor student.

Medications/Dose/Route:

Epinephrine: _____

Antihistamine: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Does this student have physician authorization to self-administer Epinephrine and to carry this medication on his/her person? Yes No

Parent/Guardian Signature

Date

Physician/Healthcare Provider Signature

Date