ALLERGY ACTION

PART I TO BE COMPLETED BY PARENT/GUARDIAN:

Student: _____ D.O.B. _____

ALLERGY: _____ Teacher/Grade: _____

1.) Emergency Contact: _____ Phone #: _____

2.) Emergency Contact: _____ Phone #: _____

Asthmatic ☐ **Yes*** ☐ **No** ***Higher Risk for severe reaction**

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER:

TREATMENT PLAN FOR ABOVE ALLERGY

For medications administered during school sanctioned activities, complete required EpiPen/Medication Authorization forms.

Symptoms:	**Give Checked Medication:**
If a food allergen has been ingested, but not symptoms:	☐ Epinephrine ☐ Antihistamine
Mouth - Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
Skin - Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
Gut - Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
*Throat - Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
*Lung - Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
*Heart - Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
*Other -	☐ Epinephrine ☐ Antihistamine
If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

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

DOSAGE	
Epinephrine: inject intramuscularly (mark one)	☐ EpiPen ® ☐ EpiPen® Jr.
Antihistamine: give	
medication/dose/route	
Other: give	
medication/dose/route	

PLACE EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

_____	_____	_____	_____
Licensed Health Care Provider (Print)	**Licensed Health Care Provider (Signature)**	**Telephone**	**Date**

I approve of this Allergy Action Plan, I give permission for school personnel to perform and carry out the tasks as outlined. I consent to the release of the information contained in this management plan to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____	_____	_____
Parent / Guardian Signature	**Telephone**	**Date**