ALLERGY ACTION PLAN

(Use 1 form per child for each allergen)

Student____________________________ School________________________________ Student Photo

DOB_____________________ Age_______ Weight__________ Grade/Rm____________

Allergy____

START DATE_______________________ END DATE_____________________________

☐ Student has Asthma (higher chance of severe reaction)
☐ Student has history of Anaphylaxis
☐ Student may self-carry Epinephrine (if yes, complete self-carry authorization form)
☐ Student may self-administer medication (If student refuses/is unable to treat, an adult must give medication)

RECOGNITION AND TREATMENT OF SYMPTOMS	Medication
☐ If student has been exposed to/ingested an allergen but has **NO** symptoms	☐ Epinephrine ☐ Antihistamine
☐ **Mouth**: Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
☐ **Skin**: Hives, itchy rash, redness, swelling of 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, wheezing, repetitive coughing	☐ Epinephrine ☐ Antihistamine
☐ **Heart**:Thready pulse,ow blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
☐ **Other**: ____	☐ Epinephrine ☐ Antihistamine
☐ **If reaction is progressing (several of the above areas affected) Give**:	☐ Epinephrine ☐ Antihistamine

ADMINISTER MEDICATION

EPINEPHRINE: (Inject Epi, call 911, request rescue squad with epinephrine)

☐ **EpiPen (0.3mg)**
☐ **Auvi-Q (0.3mg)**
☐ **Neffy (2mg)**
☐ **Other (0.3mg)** ________________________

☐ **EpiPen Jr (0.15mg)**
☐ **Auvi-Q (0.15mg)**
☐ **Neffy (1mg)**
☐ **Other (0.15mg)** ________________________

ANTIHISTAMINE: Give ____

OTHER: (E.G., Inhaler/Bronchodilator) ____

***IMPORTANT: During Anaphylaxis, epinephrine is indicated, and asthma inhalers/bronchodilators are unreliable.**

EMERGENCY CONTACTS/RELATIONSHIP	TELEPHONE NUMBER
1.________________________________	________________________________
2.________________________________	________________________________
3.________________________________	________________________________

____ ____

Parent/Guardian Signature **Date** **Physician's Signature** **Date**