ALLERGY/ANAPHYLAXIS ACTION PLAN

WALL ISD
HEALTH SERVICES

STUDENT INFORMATION:

NAME:_____DOB:_____GRADE/TEACHER:_____

ALLERGY/ANAPHYLAXIS TRIGGER:
(ex: insects/foods/plants)_____ ASTHMA: ☐YES ☐NO

SYMPTOMS EXPERIENCED DURING A REACTION (check all that apply):

- ☐ Hives
- ☐ Difficulty breathing
- ☐ Paleness
- ☐ Complaint of tingling, itchiness, or metallic taste in the mouth
- ☐ Vomiting/diarrhea
- ☐ Cramps/stomach pain
- ☐ Swelling/itching of the mouth or throat area
- ☐ Loss of consciousness
- ☐ Other_____
- ☐ Other_____

OTHER HEALTH CONDITIONS:_____
_____

CURRENT MEDICATIONS TAKEN	AMOUNT	WHEN

HOW MANY ALLERGIC/ANAPHYLACTIC REACTIONS HAS YOUR CHILD HAD?_____

WHEN WAS THE LAST REACTION?_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED DUE TO AN ALLERGIC/ANAPHYLACTIC REACTION? ☐ YES ☐ NO

DOES YOUR CHILD HAVE AN EPINEPHRINE AUTO-INJECTOR? ☐ YES ☐ NO
(If yes please complete the reverse side of this form)

CONTACT INFORMATION

PARENT/GUARDIAN:_____PHONE#_____

EMERGENCY CONTACT #1:_____PHONE#_____

EMERGENCY CONTACT #2:_____PHONE#_____

PHYSICIAN INFORMATION

PHYSICIAN/CLINIC:_____PHONE#_____

OTHER PHYSICIAN:_____PHONE#_____

School Year:_____

**See Reverse Side →

ALLERGY/ANAPHYLAXIS ACTION PLAN

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HEALTH SERVICES

SYMPTOMS OF ALLERGIC REACTION

- HIVES/ITCHING
- RUNNY NOSE/SNEEZING
- ITCHY MOUTH**
- MILD NAUSEA/DISCOMFORT
- SHORTNESS OF BREATH, WHEEZING, COUGHING**
- TROUBLE BREATHING OR SWALLOWING**
- SWELLING OF FACE, EYES, LIPS
- FACE TURNING BLUE, WEAK PULSE, DIZZINESS, CONFUSION**
- SEVERE VOMITING, DIARRHEA OR PAIN

ONLY A FEW SYMPTOMS MAY BE PRESENT. SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY.
**SOME SYMPTOMS CAN BE LIFE THREATENING. ACT FAST!

IF EXPOSED TO ALLERGENS PLEASE DO THE FOLLOWING:

☐ GIVE EPINEPHRINE

MEDICAL GUIDELINES SUGGEST GIVING EPINEPHRINE IMMEDIATELY IF…

1. IF THE CHILD IS AT RISK FOR ANAPHYLAXIS
2. IF THE CHILD IS EXPERIENCING SEVERE ALLERGIC SYMPTOMS
3. IF MULTIPLE SYMPTOMS(INCLUDING MILD ONES) ARE OCCURRING SIMULTANEOUSLY.

1. INJECT EPINEPHRINEINTO THE THIGH IMMEDIATELY!

☐ EpiPen Jr. (0.15mg) ☐ EpiPen (0.3mg)

☐ Auvi-Q (0.15mg) ☐ Auvi-Q (0.3mg)

☐ Other:_____

2. CALL 911 ASAP

REQUEST AN AMBULANCE WITH EPINEPHRINE
NOTE TIME WHEN EPINEPHRINE WAS GIVEN
A 2ND DOSE OF EPINEPHRINE MAY BE GIVEN IF SYMPTOMS DO NOT SUBSIDE AFTER FIVE MINUTES OR MORE

☐ GIVE ANTIHISTAMINE

☐ GIVE ANTIHISTAMINE IN ADDITION TO EPINEPHRINE.

☐ GIVE ANTIHISTAMINE ONLY FOR MILD SYMPTOMS. IF SYMPTOMS PERSIST OR WORSEN, GIVE EPINEPHRINE.

1. GIVE ANTIHISTAMINE

☐ Benadryl/Diphenydramine Dosage:
_____

☐ Other medication:
_____

1. ALERT PARENTS OF SYMPTOMS AND MEDICATION GIVEN.

2. MONITOR CHILD FOR AT LEAST 30 MINUTES TO SEE IF SYMPTOMS PROGRESS

Additional Comments:_____

_____

**Parent Signature:_____Date:_____

**Physician Signature:_____Date:_____

School Year:_____

**See Reverse Side →