

ALLERGY ACTION PLAN

STUDENT'S NAME : _____ TEACHER : _____
GRADE _____ BUS RIDER ? _____ BUS NUMBER : _____

ALLERGIC TO : _____

Asthma : YES _____ (if yes, higher risk for severe reaction) NO _____

➤➤STEP 1: TREATMENT

Symptoms:

Give Checked Medication

(to be determined by MD completing this plan)

- If allergen has been ingested, but *no symptoms*: Epinephrine Antihistamine
- Mouth : Itching, tingling or swelling of lips, tongue, mouth Epinephrine Antihistamine
- Skin : Hives, itchy rash, 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, repetitive coughing, wheezing ❖ Epinephrine Antihistamine
- Heart : Weak pulse, low blood pressure, fainting, pale, blue ❖ Epinephrine Antihistamine
- Other : _____ Epinephrine Antihistamine
- If reaction is progressing (several of the above areas affected), give Epinephrine Antihistamine

❖Potentially life threatening. Note that severity of symptoms can quickly change.

DOSAGE

Epinephrine : inject intramuscularly _____

Antihistamine : give _____

➤➤STEP 2: EMERGENCY CALLS

- 1) **Call 911 !** State that an allergic reaction has been treated and additional epinephrine may be needed.
- 2) Emergency contacts : Name _____ Ph # _____
Name _____ Ph # _____

EVEN IF PARENTS CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911.

Parent Signature _____ Date _____

Doctor's Signature _____ Date _____

