

**DROUGHT SCHOOL
ALLERGY ACTION PLAN**

Date _____ School _____ Grade _____

Student's Name _____ Date of Birth _____

place
child's
picture
here

ALLERGY TO: _____

STEP 1: TREATMENT

Symptoms:

Give Checked Medication:

(To be determined by physician authorizing treatment)

* If insect bite/sting occurs, but <i>no symptoms</i> :	Epinephrine	Antihistamine	Other
* If food allergen has been ingested, but <i>no symptoms</i> :	Epinephrine	Antihistamine	Other
* Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine	Other
* Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine	Other
* Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine	Other
* Throat° Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine	Other
* Lung° Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine	Other
* Heart° Weak pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine	Other
* Other° _____	Epinephrine	Antihistamine	Other

The severity of symptoms can quickly change. °Potentially life-threatening

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™0.3mg Twinject™0.15mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

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

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship _____ Phone Numbers(s) _____
a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Physician's Signature _____ Date _____

Physicians' Name (Printed) _____ Address _____ State/Zip Code _____

**Adapted from The Food Allergy & Anaphylaxis Network. Used with permission.