

# ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

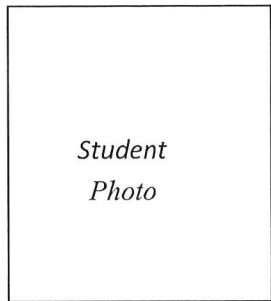
Student \_\_\_\_\_ School \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Grade/Rm \_\_\_\_\_

Allergy to \_\_\_\_\_

START DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_

- Student has asthma.  Yes  No (If yes, higher chance of severe reaction)
- Student has had anaphylaxis.  Yes  No
- Student may carry epinephrine.  Yes  No (if yes, complete next page)
- Student may give him/herself medicine.  Yes  No (If student refuses/is unable to self-treat, an adult must give medicine.)



## IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p><b>For Severe Allergy and Anaphylaxis</b></p> <p><b>What to look for</b></p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, <b>give epinephrine.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shortness of breath, wheezing, or coughing</li> <li><input type="checkbox"/> Skin color is pale or has a bluish color</li> <li><input type="checkbox"/> Weak pulse</li> <li><input type="checkbox"/> Fainting or dizziness</li> <li><input type="checkbox"/> Tight or hoarse throat</li> <li><input type="checkbox"/> Trouble breathing or swallowing</li> <li><input type="checkbox"/> Swelling of lips or tongue that bother breathing</li> <li><input type="checkbox"/> Vomiting or diarrhea (if severe or combined with other symptoms)</li> <li><input type="checkbox"/> Many hives or redness over body</li> <li><input type="checkbox"/> Feeling of "doom," confusion, altered consciousness, or agitation</li> </ul> <p><input type="checkbox"/> <b>SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):</b> _____ <b>Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</b></p>	<p><b>Give epinephrine!</b></p> <p><b>What to do</b></p> <ol style="list-style-type: none"> <li>1. Inject epinephrine right away! Note time when epinephrine was given.</li> <li>2. Call 911.             <ul style="list-style-type: none"> <li><input type="checkbox"/> Ask for ambulance with epinephrine.</li> <li><input type="checkbox"/> Tell rescue squad when epinephrine was given.</li> </ul> </li> <li>3. Stay with child and:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Call parents and child's doctor.</li> <li><input type="checkbox"/> Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.</li> <li><input type="checkbox"/> Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.</li> </ul> </li> <li>4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.             <ul style="list-style-type: none"> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Inhaler/bronchodilator</li> </ul> </li> </ol>
<p><b>For Mild Allergic Reaction</b></p> <p><b>What to look for</b></p> <p>If child has had any mild symptoms, <b>monitor child.</b></p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Itchy nose, sneezing, itchy mouth</li> <li><input type="checkbox"/> A few hives</li> <li><input type="checkbox"/> Mild stomach nausea or discomfort</li> </ul>	<p><b>Monitor child</b></p> <p><b>What to do</b></p> <p>Stay with child and:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Watch child closely.</li> <li><input type="checkbox"/> Give antihistamine (if prescribed).</li> <li><input type="checkbox"/> Call parents and child's doctor.</li> <li><input type="checkbox"/> If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")</li> </ul>

## Medication/Doses

Epinephrine autoinjector, intramuscular (list type): \_\_\_\_\_ Dose:  0.15 mg  0.30 mg

Antihistamine, by mouth (type and dose): \_\_\_\_\_

Other (for example, inhaler/bronchodilator if student has asthma): \_\_\_\_\_

<p>Parent/Guardian Authorization Signature</p>	<p>Date</p>	<p>Physician/HCP Authorization Signature</p>	<p>Date</p>
<p>Emergency Contacts/Relationship</p>	<p>Telephone number</p>		
<p>1. _____</p>	<p>_____</p>		
<p>2. _____</p>	<p>_____</p>		
<p>3. _____</p>	<p>_____</p>		