Allergy Action Plan

Child's Name: ______________________________ D.O.B: _____________ Child's Current Weight: ___________

Food Allergies:
Foods my child is allergic to and must avoid. Are these allergies consumption, contact, or both?

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____

Other Allergies:
Medication or other substances that must be avoided due to allergies.

____

____

Symptoms:
What are the typical signs and symptoms when your child is having an allergic reaction?
Please indicate whether the child can report symptoms, the time period over which symptoms might emerge, and the severity of the anticipated reaction. ____

____

____

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:
• If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen ☐ Antihistamine
• Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen ☐ Antihistamine
• Skin:	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen ☐ Antihistamine
• Gut:	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen ☐ Antihistamine
• Throat*:	Tightening of throat, hoarseness, hacking cough	☐ EpiPen ☐ Antihistamine
• Lung*:	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen ☐ Antihistamine
• Heart*:	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen ☐ Antihistamine
• Other*:	______________________________	☐ EpiPen ☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ EpiPen ☐ Antihistamine

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

<u>**Medication Dosages:**</u>
Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 1.15mg

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

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STEP 2: EMERGENCY CALLS, IF NECESSARY

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

2. Dr. ______________________________ Phone: ____________________________

3. Parent ___________________________ Phone Number(s): 1. _________________ 2. __________________

4. Emergency contacts (if parent cannot be reached):

Name & Relationship Phone Number(s)

a. ______________________________________ 1.)__________________ 2.) _________________

b. ______________________________________ 1.)__________________ 2.) _________________

c. ______________________________________ 1.)__________________ 2.) _________________

I have read, understood, and agree with this plan. I approve the release of this information to classroom staff and emergency medical personnel.

Parent/Guardian Signature______________________________________ Date____________