Known Allergies:
_____
_____
_____
_____

Student Allergy Action Plan 2024-2025

(To be completed and signed by physician)

Student Photo Here

Student Name: _____ Grade: _____ Date of Birth: _____

STEP 1: TREATMENT

Asthmatic: ☐ Yes* ☐ No * Higher risk for severe reaction

Symptoms:	**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
If a student has come in contact with allergen, but no symptoms	☐ Epinephrine	☐ Antihistamine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin – Hives itchy rash, swelling of the 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** - Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other** - _____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affect), give	☐ Epinephrine	☐ Antihistamine

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

Dosage:

Epinephrine: inject intramuscularly (check one) ☐ Epi Pen ☐ Epi Pen Jr. ☐ Twinject 0.3mg ☐ Twinject 0.15mg

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____.
3. Emergency Contacts:

Name/Relationship	Phone numbers
a) _____	1. _____ 2. _____
b) _____	1. _____ 2. _____

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

_____
Physician's Signature ***Date of Examination***

_____
Parent's Signature ***Date***