

# Severe Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

## STEP 1: TREATMENT

### Symptoms:

### Give Checked Medication

\*\*(To be determined by physician authorizing treatment)

- |                                  |  |                                      |  |
|----------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> Mouth   | Itching, tingling, or swelling of lips, tongue, mouth                  | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Skin    | Hives, itchy rash, swelling of the face or extremities                 | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Gut     | Nausea, abdominal cramps, vomiting, diarrhea                           | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Throat† | Tightening of throat, hoarseness, hacking cough                        | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Lung†   | Shortness of breath, repetitive coughing, wheezing                     | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Heart†  | Thready pulse, low blood pressure, fainting, pale, blueness            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Other†  | _____  | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/>         | If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

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

### DOSAGE

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

**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 been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Parents \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

4. Emergency contacts:

Name/Relationship \_\_\_\_\_ Phone Number(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 \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)