Severe Allergy Action Plan

Student's Name: **D.O.B:** **Teacher:**

Place Child's Picture Here

ALLERGY TO:

Asthmatic: ___ Yes* ___No *Higher risk for severe reaction

• STEP 1: TREATMENT •

Symptoms:		**Give Checked Medication**:**
		**(To be determined by physician authorizing treatment)
• If ingestion of or 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†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	__ Epinephrine __Antihistamine
• Other†	_____	__ Epinephrine __Antihistamine
• If reaction is progressing (several of the above areas affected), give:		__ Epinephrine __ Antihistamine

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

If epinephrine administered, CALL 911

MEDICATION:

_____ Medication authorization form for antihistamine completed and attached

_____ Medication authorization form for epinephrine completed and attached

A medication authorization form must be completed for each medication to be administered at school. The form must be signed by both the physician and parent.

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

STEP 2: EMERGENCY CALLS •

1. **Call 911**. State that an allergic reaction has been treated with epinephrine. **Note time epinephrine given**.

2. Dr._____Phone Number:_____

3. Parent_____ Phone Number(s):_____

4. Emergency Contact: _____ Phone Number(s): _____

Parent/Guardian's Signature:_____ **Date**:_____

Physician's Signature:_____ **Date**: _____

(Required)

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*