Academics Inspired by Faith
SAINT ROSE
CATHOLIC SCHOOL

Allergy Action Plan

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

ALLERGY TO: _____

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

****STEP 1: TREATMENT****

Symptoms:	**Give Checked Medications** ****(To be determined by physician authorizing treatment)**
If a food allergen has been ingested, 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 affected) give:	_____Epinephrine _____Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject .15

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.

over

Academics Inspired by Faith
SAINT ROSE
CATHOLIC SCHOOL

Allergy Action Plan

****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. _____ at _____

3. Emergency Contacts:

	Name/Relationships	Phone Number(s)
a.	_____	**1)** _____ **2)**_____
b.	_____	**1)** _____ **2)**_____
c.	_____	**1)** _____ **2)**_____

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

over