

# Life-Threatening Allergy Action Plan

School Year \_\_\_\_\_

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Physician / Healthcare Provider	Phone:	

**THIS SECTION IS TO BE COMPLETED BY PHYSICIAN**

**ALLERGY TO:**

Asthmatic  Yes\*  No \* Higher risk for severe reaction

**STEP 1: TREATMENT**

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**SYMPTOMS:**

- If a food allergen has been ingested, but no symptoms
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give

**GIVE CHECKED MEDICATION**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

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

**MEDICATION DOSAGE & ROUTE**

**Antihistamine:**

Dose: \_\_\_\_\_

**Epinephrine:**

Inject epinephrine in thigh using (check one):

- |  |   |
|--|---|
| <input type="checkbox"/> Adrenaclick (0.15 mg) | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> EpiPen Jr (0.15 mg)   | <input type="checkbox"/> EpiPen (0.3 mg)      |

Epinephrine Injection, USP Auto-injector- authorized generic

- |  |   |
|--|---|
| <input type="checkbox"/> (0.15 mg)       | <input type="checkbox"/> (0.3 mg)       |
| <input type="checkbox"/> Other (0.15 mg) | <input type="checkbox"/> Other (0.3 mg) |

**Other:** \_\_\_\_\_

(PRINTED NAME OF PHYSICIAN)

(SIGNATURE OF PHYSICIAN / DATE)

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**STEP 2: EMERGENCY CALLS**

911 CALL REQUIRED UPON EPI-PEN DELIVERY.

NOTIFY Parent/Guardian of all allergic reactions and treatment.

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

2 Emergency Contact Person:

Contact Phone(s):

*The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.*

Parent/Guardian Signature \_\_\_\_\_

DATE \_\_\_\_\_