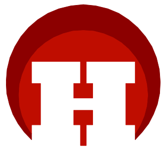

Highland Community School

place child's picture here

ALLERGY ACTION PLAN FORM

Students Name:________________________________ Date of Birth: __________________
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 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 ☐
• Stomach – Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine: ☐	Antihistamine ☐
• Throat*- tightening of the throat, hoarseness, hacking cough.	Epinephrine: ☐	Antihistamine ☐
• Lung*- shortness of breath, repetitive coughing, wheezing.	Epinephrine: ☐	Antihistamine ☐
• Heart- thread 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 the symptoms can quickly change. *Potentially life-threatening.

Dosage:
Epinephrine: Inject intramuscularly (Circle one) EpiPen® EpiPen®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 I anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (state that all allergic reaction has been treated, and additional epinephrine may be needed.)
2. Parents/Guardian:____________________________ Phone#'s:______________________________
____
3. Emergency contacts:

____ ____________________________________
Name/Relationship Phone Numbers

____ ____________________________________
Name/Relationship Phone Numbers

Parent/Guardian Signature:________________________ Date:_______________________
REQUIRED

Doctor's Signature:___________________________________ DATE:_________________________
REQUIRED