ALLERGY/ ANAPHYLAXIS ACTION PLAN

Student Name:	DOB:	Teacher:	·····	
Health Care Provider:		Phone:		
History of Asthma: No	Yes - Higher risk for s	severe reaction		
Foods (list):Medications (list):	To be completed by Health C			
Chart to be completed by Health Care Provider ONLY		Give CHECKED Medication		
If food ingested or contact with allergen occurs:		EpiPen	Antihistamine	
No symptoms notes	☐ Observe for other syr	mptoms		
Mouth	Itching, tingling, or swelling o	f 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	e coughing, wheezing		
Heart ⁺	Thready pulse, low BP, faintii	ng, pale, blueness		
Neuro ⁺	Disorientation, dizziness, loss of conscience			
If reaction is progressing (several of the above areas affected), GIVE:				
The severity of symptoms ca	n quickly change. *Potentially	life-threatening.		
Antihistamine: Benadryl Other: This child has received SHOULD be allowed to and has been advised.	thigh □ EpiPen 0.3mg OR mg. To be given by modern by modern by modern by modern by modern by the proper use of the conform a responsible adult it binion that this student SHOUL	outh only if able to swallow of the EpiPen. It is my properties the child known in the EpiPen is self-admin	w. ofessional opinior nows when to requistered.	that this student
Health Care Provider Signatur		· .		
Phone:	Date:			

EMERGENCY CALLS

- 1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- 2. Call parents/ guardian to notify of reaction, treatment, and student's health status.