

# Allergy Action Plan

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Program: ERfC

ALLERGY TO: \_\_\_\_\_

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

Has your child had a previous allergic reaction? Yes  No

Was your child brought to the Emergency Room? Yes  No

## Symptoms

PLEASE CIRCLE SYMPTOMS CHILD HAS EXPERIENCED IN THE PAST:

- 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 ☹ \_\_\_\_\_

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

## STEP ONE – TREATMENT:

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: give \_\_\_\_\_

Other: give \_\_\_\_\_

## STEP TWO: EMERGENCY CALLS

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

2. Call Parent/Guardian:

Name/Relationship	Phone #1	Phone #2
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

3. Call ERfC office to report incident

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

Health Care Consultant Signature \_\_\_\_\_ Date \_\_\_\_\_