MEDICAL ACTION PLAN

Allergies

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

ALLERGY TO:_____

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

►STEP 1: TREATMENT◄

Symptoms:	**Give Checked Medication**:** (**To be determined by physician)
•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†: Weak or thready pulse, lowe blood pressure, fainting	☐Epinephrine ☐ Antihistamine
•Other†:	☐Epinephrine ☐ Antihistamine
•If reaction is progressing (several of the above areas affected), give	☐Epinephrine ☐ Antihistamine

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

DOSAGE:

Epinephrine: inject intramuscularly (circle one): Epipen® Epipen Jr.® Twinject™0.3mg Twinject™

Antihistamine: give _____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anapylasix.

►STEP 2: EMERGENCY CALLS◄

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ Phone Number:_____
3. Call Parent _____ Phone Number:_____
4. Emergency Contacts:
   Name/Relationship Phone Number(s)

a.)_____ 1)_____ 2)_____

b)_____ 1)_____ 2)_____

EVEN 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)

☐ **I give my permission to share this information with the lunchroom personnel.**