



ALLERGY ACTION PLAN

Summer 2013

Name: _____ Date of Birth: _____

Allergic to: _____ Asthmatic? ☐ Yes ☐ No

STEP 1: TREATMENT

SYMPTOMS	Give Checked Medication To be determined by physician authorizing treatment	
No symptoms: If a food allergen has been ingested, but <i>no symptoms</i>	☐ 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 [†] : Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other [†] (please specify): _____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine
[†]Potentially life-threatening.		
DOSAGE		
Epinephrine: inject intramuscularly using: ☐ 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 in anaphylaxis.		

STEP 2: EMERGENCY CALLS

	Name	Phone Number(s)
1. 911: State that an allergic reaction has been treated, and additional epinephrine may be needed.		
2. Physician		
3. Mother		
4. Father		
5. Emergency Contact 1 (Relationship: _____)		
6. Emergency Contact 2 (Relationship: _____)		
EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!		

Signature of Parent or Guardian _____ Date _____

Signature of Physician (required) _____ Date _____