ALLERGY ACTION PLAN

Summer 2017

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 ***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†: 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. ❑ Auvi-Q™ 0.3mg ❑ Auvi-Q™ 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** _____

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