

# BIG WALNUT

## LOCAL SCHOOL DISTRICT

PLACE  
CHILD'S  
PICTURE  
HERE

### ALLERGY ACTION PLAN FORM

(This form must be completed by Physician & signed by Parent & Physician)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergy to: \_\_\_\_\_

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

Please list foods to be substituted for food allergy: \_\_\_\_\_

### STEP 1: TREATMENT

#### Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth – itching, tingling, or swelling of lips, tongue, mouth
- Skin – hives, itchy rash, swelling of the face or extremities
- Stomach - Nausea, abdominal cramps, vomiting, diarrhea
- Throat \* – tightening of throat, hoarseness, hacking cough
- Lung\* - shortness of breath, repetitive coughing, wheezing
- Heart\* - thread pulse, low blood pressure, fainting, pale, blueness
- Other\* - \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give  
The severity of symptoms can quickly change. \*Potentially life-threatening

#### Give Checked Medication\*\*:

\*\*(To be determined by physician authorizing treatment)

- |                                      |  |
|--------------------------------------|--|
| Epinephrine <input type="checkbox"/> | Antihistamine <input type="checkbox"/> |
| Epinephrine <input type="checkbox"/> | Antihistamine <input type="checkbox"/> |
| Epinephrine <input type="checkbox"/> | Antihistamine <input type="checkbox"/> |
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| Epinephrine <input type="checkbox"/> | Antihistamine <input type="checkbox"/> |

#### Dosage:

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™0.3mg Twinject™0.15mg  
(see reverse side for instruction)

**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

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

2. Parents/Guardian: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

3. Emergency contacts:

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Phone Numbers

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Phone Numbers

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

REQUIRED

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED