

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