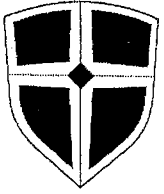

Southwest Christian School

Allergy Action Plan
Date: ________________
School Year: __________
Teacher:______________

Student:____ DOB:_________________

Allergy:____

Action Plan– Parent /guardian is responsible for all medication &supplies:

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
Stomach- 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*-	___Epinephrine	___Antihistamine
If reaction is progressing and several of the above areas affected	___Epinephrine	___Antihistamine

***Potentially life threatening**, the severity of symptoms can quickly change.

Dosage:

Antihistamine: give____

Medication/dose/route

Other: give____

Medication/dose/route

If symptoms do not improve in _______ minutes:

____Repeat medications above

____Administer Epinephrine: inject intramuscularly (circle one) EpiPen Epi Pen Jr Twinject 0.3mg Twinject 0.15mg

____ Call EMS

____ Contact parent/guardian for further instructions.

Any other pertinent information regarding your child's allergies:_____________________________

____

____

Physician's signature:_______________________ Date:___________ Phone:________________