Allergy Action Plan

Child's picture

Student's Name_____

Allergy To:_____

Check All that Apply	**Signs of Allergic Reaction**
☐ **Itching**	
☐ **Hives**	
☐ **Rash**	
☐ **Swelling or redness at sting site**	
☐ **Itching/swelling lips, tongue, or mouth**	
☐ **Trouble breathing, swallowing, talking**	
☐ **Nausea/Vomiting**	
☐ **Other (specify)**_____	

Treatment

I request that the following medication be kept in the health office and be administered as ordered. Parents must supply the medication. If emergency medications indicated on this plan are not provided-----911 will be called as needed.

1. Give medication:_____ Dose:_____Route:_____

if symptoms are:_____

2. Give medication_____Dose:_____Route:_____

if symptoms are:_____

3. **Call 911 if Epi Pen Given or if Reaction Severe**

4. Call parents or emergency contacts as designated on back of this plan.

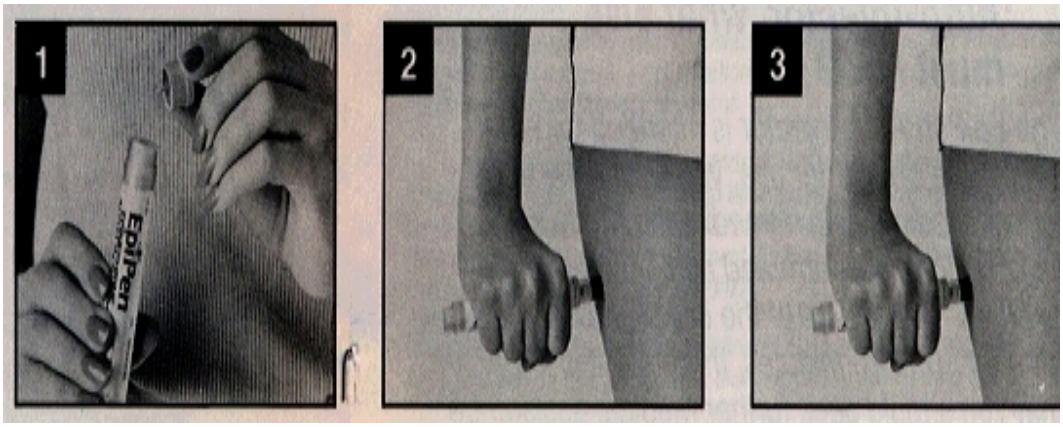
Student Signature_____***Date***_____

Parent Signature_____***Date***_____

Physician Signature_____***Date***_____

☐_I give permission for this student to carry own epi-pen with them on the school campus_____

Physician Signature



1. Have some one activate the emergency system and call 911.
2. Pull off grey activation cap.
3. Hold black tip near outer thigh (always apply to thigh).
4. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The Epi-Pen® unit should then be removed.
5. Stay with student until paramedics arrive.
6. Be careful to dispose Epi-Pen® in sharps container.

Emergency Contacts

Name:	Relationship:	Daytime Phone Number: Cell:
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Name:	Relationship:	Daytime Phone Number: Cell:

Date Received in the health office_____

Nurse's
signature_____

Trained Staff Members		
Name:	Date:	Initials
Name:	Date:	Initials
Name:	Date:	Initials
Name:	Date:	Initials
Name:	Date:	Initials
Name:	Date:	Initials