Allergy Emergency Action Plan

Student's Name: _____ D.O.B. _____HR:_____

ALLERGIC TO:_____

Parent/Guardian name and cell phone number:

Mother: _____

Father: _____

Other emergency contact name/cell #: _____

If These Symptoms Occur:	**Then Give:** (circle medication)	
• Allergen has been ingested, no symptoms	Epinephrine	Antihistamine
• Mouth: itching/tingling or swollen lips/tongue	Epinephrine	Antihistamine
• Skin: hives/rash/ or swelling	Epinephrine	Antihistamine
• GI: nausea/abdominal pain/vomiting	Epinephrine	Antihistamine
• Tightening of throat/hoarseness/cough	Epinephrine	Antihistamine
• Shortness of breath/coughing/wheezing	Epinephrine	Antihistamine
• Low blood pressure/fainting/pale or blue	Epinephrine	Antihistamine
• Other _____	Epinephrine	Antihistamine
• If reactions are progressing (several of the above)	Epinephrine	Antihistamine

Medication to be administered:

Epinephrine: inject intramuscularly (circle all that apply) EpiPen@ EpiPen@ Jr . Twinject™ 0.3 mg Twinject™ 0.15 mg

If epinephrine is administered during a reaction, call 911, State that an allergic reaction has been treated, and additional epinephrine may be needed. Send the used epinephrine injection device with the student to the Emergency Room.

Antihistamine: give: _____
medication/dose/route/frequency

***Other**: give: _____
medication/dose/route/frequency

Doctor's Signature:_____Date:_____
(required)

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of the above-named student, request this emergency action plan be used to guide allergy care for my child. I agree to:

- Provide necessary supplies and equipment, including EpiPen@ and Antihistamine if prescribed.
- Notify school administration of any changes in the student's health status.
- Notify the school and complete new consent for changes in orders from the student's health care provider.
- Authorize the school to communicate with _____, the primary care provider/specialist about allergy as needed. Allow school staff interacting directly with my child to be informed about his/her special needs while at school.

Parent/Guardian Signature_____Date_____