Allergy Emergency Action Plan

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

ALLERGIC TO:_____

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

★ **Epinephrine** will be administered per label instructions.
★ **Antihistamine** directions: _____

Physician Signature **(required)**: _____ Date:_____

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Parent/Guardian name and cell phone number:

Mother: _____

Father: _____

Other emergency contact name/cell #: _____

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of the above-named student, request that 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 a 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 to interact directly with my child to be informed about his/her special needs while at school.

Parent/Guardian Signature _____ Date_____