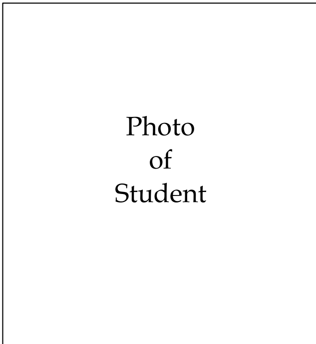
Merritt ACADEMY
Enjoy the Journey

Allergy Action Plan



Student's Name: ____________________D.O.B. ____________ Teacher/Classroom: _______________

ALLERGIC TO:

____

Childs Weight ___ ______

Asthmatic: ☐ Yes ☐ No

♦ Allergy Action Plan

SIGNS OF AN ALLERGIC REACTION	**MEDICATION** **Please indicate which medication we should give first, second or N/A.** **Please circle action required for each symptom.** ***NOTE: every box should have a selection- either 1st, 2nd or N/A.***

Category	Symptom (s)	Epinephrine	Antihistamine
___	No symptoms and *suspected* ingestion of allergen.	NA *	NA
___	No symptoms and *known* ingestion of allergen.	NA *	NA
Mild Symptoms	One symptom of the following: Itching, tingling of lips, tongue, or mouth. Localized hives and/or itchy rash. Hay fever like symptoms (runny nose, red eyes).	NA *	NA
Severe Symptoms	One of these symptoms or multiple mild symptoms: Hives on more than one part of the body, swelling of face or extremities, nausea, abdominal cramps, vomiting or diarrhea, hacking cough, tightening of throat or difficulty swelling, shortness of breath, wheezing or weak pulse, low blood pressure, fainting, dizzy or pale.	NA *	NA
Other		NA *	NA

***If symptoms do not improve within 5 minutes of administering epinephrine, give a second dose.**

DOSAGE:

Epinephrine: inject intramuscularly: ____

Antihistamine: ____
medication name/dose

Other: ____

We encourage you to consult with your child's physician to make sure the best action plan is in place.

______________________ ______________________ ____________

Parent Signature *Parent Name* *Date*