



Photo
of
Student

Student's Name: _____ D.O.B. _____ Teacher/Classroom: _____

ALLERGIC TO:

Child's 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. <i>NOTE: every box should have a selection either 1st, 2nd or N/A.</i>	
Category	Symptom (s)	Epinephrine	Antihistamine
—	No symptoms and <i>suspected</i> ingestion of allergen.	*	
—	No symptoms and <i>known</i> ingestion of allergen.	*	
<i>Mild Symptoms</i>	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).	*	
<i>Severe Symptoms</i>	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.	*	
<i>Other</i>		*	

***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