Fremont City Schools

Allergy Action Plan

Student's Name _____ **D.O.B.** _____ **Teacher:** _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆STEP 1: TREATMENT ◆

Symptoms:	**Give Checked Medication **:** (To be determined by physician authorizing treatment)
• If exposed to an allergen, but no symptoms:	0 Epinephrine 0 Antihistamine
• Mouth Itching, tingling or swelling of lips, tongue, mouth	0 Epinephrine 0 Antihistamine
• Skin Hives, itchy rash, swelling or face or extremities	0 Epinephrine 0 Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	0 Epinephrine 0 Antihistamine
• Throat† Tightening of throat, hoarseness, hacking cough	0 Epinephrine 0 Antihistamine
• Lung † Shortness of breath, repetitive coughing, wheezing	0 Epinephrine 0 Antihistamine
• Heart† Thready pulse, low blood pressure, fainting, pale, blueness	0 Epinephrine 0 Antihistamine
• Other † _____	0 Epinephrine 0 Antihistamine
• If reaction is progressing (several of the above areas affected), give	0 Epinephrine 0 Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give: _____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS◆

1. Call 911 (or Rescue Squad: _____) State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Parent _____ Phone Number(s) _____

3. Dr. _____ Phone Number(s)_____

4. Emergency contacts
Name/Relationship Phone Number(s)
a. _____ 1.) _____ 2.) _____
b. _____ 1.) _____ 2.) _____
c. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESISTATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Parent/Guardian Signature: _____ Date: _____
Doctor's Signature: _____ Date: _____
(Required)