Alamance Community School
Allergy Action Plan

Students Name:_____ **D.O.B:**_____

ALLERGY TO:_____

Asthmatic ☐Yes* ☐No *Higher risk for severe reaction

SYMPTOMS:	Give checked medication as determined by Physician:
If an exposure to the allergen has occurred, but there are NO symptoms:	☐Antihistamine ☐Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Antihistamine ☐Epinephrine
Skin: Hives, itchy rash, swelling of the face or extremities	☐Antihistamine ☐Epinephrine
♦Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Antihistamine ☐Epinephrine
♦Throat: Tightening of throat, hoarseness, hacking cough	☐Antihistamine ☐Epinephrine
♦Lung: Shortness of breath, repetitive coughing, wheezing	☐Antihistamine ☐Epinephrine
♦Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Antihistamine ☐Epinephrine
Other symptoms:	☐Antihistamine ☐Epinephrine
If reaction is progressing, several of the above areas affected:	☐Antihistamine ☐Epinephrine

♦Potentially life threatening. The severity of symptoms can quickly change.

DOSAGE:

Epinephrine: inject intramuscularly (see reverse side for instructions)

☐EpiPen® ☐EpiPen® Jr. ☐Twinject® 0.3 mg ☐Twinject® 0.15 mg

Antihistamine: _____
Medication/Dose/Route

Other:_____
Medication/Dose/Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor:_____ Phone Number:_____
3. Parent:_____ Phone Number:_____
4. Other Emergency Contacts:

   Name:_____ Phone Number:_____

   Name:_____ Phone Number:_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO A MEDICAL FACILITY!

Parent/Guardians Signature:_____ Date:_____

Physicians Signature:_____ Date:_____
Required