Walnut Grove Christian School
Allergy Action Plan Form

Student's Name: _____ Date of Birth: _____

Allergy To: _____

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

STEP 1: TREATMENT

Symptoms:		**Give checked medication*** *To be determined by physician
•	If a food allergen has been ingested, but no symptoms:	□Epinephrine □Antihistamine
•	Mouth Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine □Antihistamine
•	Skin Hives, itchy rash, swelling of the face or extremities	□Epinephrine □Antihistamine
•	Gut Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine □Antihistamine
•	Throat* Tightening of throat, hoarseness, hacking cough	□Epinephrine □Antihistamine
•	Lung* Shortness of breath, repetitive coughing, wheezing	□Epinephrine □Antihistamine
•	Heart* Rapid pulse, low blood pressure, fainting, pale, blueness	□Epinephrine □Antihistamine
•	Other* _____	□Epinephrine □Antihistamine
•	If reaction is progressing (several of the above areas affected), give	□Epinephrine □Antihistamine

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

Dosage:
Epinephrine: inject intramuscularly (circle one) EpiPen, EpiPen Jr, Twinject 0.3mg, Twinject 0.15mg

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

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

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. Dr. _____ Phone Number: _____
3. Parents _____ Phone Number(s): _____
4. Emergency Contacts:
   Name/Relationship Phone Number(s)
   _____ _____
   _____ _____

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

Parent/Guardian Signature _____ Date _____
Physician's Signature _____ Date _____
(Required)