School Year: _____

Severe Allergy Action Plan

To be determined by physician authorizing treatment.

Place Child's Picture Here

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 a child has had contact with an allergen, but no symptoms	☐ EpiPen ☐ Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen ☐ Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	☐ EpiPen ☐ Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen ☐ Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	☐ EpiPen ☐ Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	☐ EpiPen ☐ Antihistamine
Heart† Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen ☐ Antihistamine
Other† _____	☐ EpiPen ☐ Antihistamine
If reaction is progressing (several of the above areas affected), give	☐ EpiPen ☐ Antihistamine

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

DOSAGE

To be determined by physician authorizing treatment:

Epinephrine: inject intramuscularly (circle one)

EpiPen 0.3mg EpiPen Jr. 0.15mg Auvi-Q 0.3mg Auvi-Q 0.15mg

Antihistamine: give medication/dose/route_____

Other: give medication/dose/route_____

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

While in the care of the Child Enrichment Center this child's emergency epinephrine MUST be accessible to the child at all times.

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 #: _____

3. Parent _____ Phone#: _____

4. Emergency contacts:

Name/Relationship Phone Number(s)

a. _____ Relationship: _____ Phone #: _____

b. _____ Relationship: _____ Phone #: _____

c. _____ Relationship: _____ Phone #: _____

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

By signing this form I give the Child Enrichment Center staff permission to administer medication as specified on this form.

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature_____ Date: _____

(Required)