ALLERGY ACTION PLAN – Requires PCP Signature

Student ____ DOB: _____________ GR: __________

ALLERGY TO: ____

Asthmatic: YES * NO *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION – Systems: Symptoms:

- MOUTH: itching and swelling of the lips, tongue, or mouth
- THROAT*:itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN: hives, itchy rash, and/or swelling about the face or extremities
- GUT: nausea, abdominal cramps, vomiting and/or diarrhea
- LUNG*: shortness of breath, repetitive coughing and/or wheezing
- HEART*: “thread” pulse, “passing out”

The severity of the symptoms can quickly change. *All above symptoms can potentially progress to a life- threatening situation.

MEDICATIONS TO BE GIVEN (Antihistamine etc.)

______________________ _________________________ ____________________________

Epinephrine 0.15mg/0.3mg Epinephrine IM to outer thigh (PCP Please circle)

1. NOTIFY: Parent/Guardian:____

PCP SIGNATURE: _____________________________________ DATE: _____________ STAMP__________

PARENT SIGNATURE: ___________________________________DATE:_______________

THEN CALL

1. 911
2. PARENT/GUARDIAN: ___________________________at_________________________________
3. PCP: __________________________________at______________________________________

DO NOT HESITATE TO CALL 911

School RN Signature: ____ Date: _____________________

Please turn over

TO BE COMPLETED FOR SELF- MEDICATION ONLY: (School trips, asthma inhalers, etc.)

____ has been instructed in the proper use of this medication

____and is permitted to carry the medication on his/her person, or to keep same in his her locker or PE locker, as we consider him/her responsible for self-administration. This student is aware of the proper dosage, route of administration, appropriate time to administer, as well as signs or symptoms that indicate appropriate time to use.

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Signature (Parent/Guardian) Prescriber's Signature