SAINT ROSE OF LIMA SCHOOL

Learning, Loving, and Serving the Lord

Allergy Action Plan

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

Teacher and Grade: _____

ALLERGY TO: _____

**Asthmatic ___ Yes ___ No *Higher Risk for severe reaction*

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication:**	
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, receptive coughing, wheezing	___ Epinephrine	___ Antihistamine
Heart: Thready pulse, low Blood Pressure, fainting, pale, cyanosis	___ Epinephrine	___ Antihistamine
Other: _____	___ Epinephrine	___ Antihistamine
If reaction is progressing (several of the above areas affected), Give:	___ Epinephrine	___ Antihistamine

Dosage:

Epinephrine Type and Dose : _____

Antihistamine Type and Dose: _____

Other Medication: _____

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

STEP 2: TREATMENT

****Do NOT hesitate to medicate affected student as written above. Then do the following:**

1. Call 911. State that an allergic reaction has been identified and treated according to the action plan, and additional epinephrine may be needed. Student may be taken to medical facility for further treatment via ambulance.

2. Emergency Contact: _____

Parent/Guardian Signature_____ Date_____

Doctor's Signature (Required)_____ Date_____

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