Allergy Action Plan

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

Place Child's Picture Here

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 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† Thready 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

ANTIHISTAMINE: give_____
medication/dose/route

EPINEPHRINE: ***inject intramuscularly (circle one)*** *EpiPen®* *EpiPen® Jr.* *Twinject™ 0.3 mg* *Twinject™ 0.15 mg*

Other: give_____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts: Name/Relationship Phone Number(s)

a. _____ 1.)_____ 2.) _____

b. _____ 1.)_____ 2.) _____

c. _____ 1.)_____ 2.) _____

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

STEP 3: ACCOMMODATIONS

1. In the cafeteria, does this child need to be seated at a "peanut-free table", where no peanut products are allowed? ☐YES ☐ NO

2. Please list any other accommodations required in school : _____

_____

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

10/12/05

EAST SYRACUSE MINOA SCHOOL DISTRICT

MEDICATION / TREATMENT FIELD TRIP FORM

Student's Name: _____ Gr / Teacher: _____

Medication: _____

PLEASE SIGN ONE:

If your child needs medication or a medical treatment on a field trip and is **not self-directed** (able to carry and take his/her own medication), it is strongly suggest that you accompany your child on the field trip for his or her safety.

I will attend the field trip with my child.

Parent Signature: _____ Date: _____

If you are unable to attend the field trip, you may **designate someone else to accompany your child.** Please indicate below who you have designated, that you have trained them to administer the medication / treatment to your child and that you have provided them with the required medication from home.

Name and phone number of the adult, trained by you, who will attend the field trip with your child: _____

Parent Signature: _____ Date: _____

If no one is able to accompany your child, please sign below and notify your child's school nurse immediately.

Parent Signature: _____ Date: _____

3/9/11