SAN CARLOS SCHOOL DISTRICT
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Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ DOB: _____ Teacher: _____

ALLERGY TO: _____

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

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 affected areas) 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 Auvi-Q

Epinephrine Should be kept (circle): With child In child's classroom with teacher In front office

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

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

STEP 2: EMERGENCY CALLS

1. **CALL 911. State that an allergic reaction has been treated and additional epinephrine may be needed.**
2. **Call Dr: _____ at Phone Number: _____ at _____**
3. **Call Parents: _____ at Phone Number(s) _____**
4. **Emergency Contacts:**
   Name/Relationship Phone Number(s)
   a._____ 1. _____ 2. _____
   b._____ 1. _____ 2. _____

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

Parent/Guardian Signature _____ **Date:** _____

Doctor's Signature _____ **Date:** _____