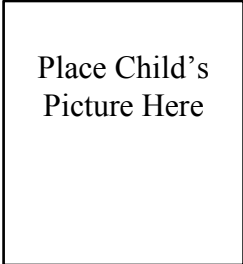




SAN CARLOS SCHOOL DISTRICT
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Mary Jude Doeringhaus, Assistant Superintendent

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Allergy Action Plan



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:

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+: _____
 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 epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

- CALL 911. State that an allergic reaction has been treated and additional epinephrine may be needed.**
- Call Dr:** _____ **at Phone Number:** _____ **at** _____
- Call Parents:** _____ **at Phone Number(s)** _____
- 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:** _____