Whitfield County/ Dalton City School Health Program

Allergy Action Plan

Place picture of child here.

Student's Name_____DOB_____Teacher _____

Allergy to:_____

Asthmatic Yes*_____ No___/___ *Higher risk for severe reaction

♦Step 1: Treatment♦

****To be determined by physician authorizing treatment**

Symptoms:	Administer checked medication**
♦Mouth: Itching, tingling, or swelling of lips, tongue, mouth	____ Epi-pen _____Antihistamine
♦Skin: Hives, Itchy rash, swelling of face or extremities	____ Epi-pen _____Antihistamine
♦Gut: Nausea, abdominal cramps, vomiting, diarrhea	____ Epi-pen _____Antihistamine
♦Throat*: Tightness of throat, hoarseness, hacking cough	____ Epi-pen _____Antihistamine
♦Lung*: Shortness of breath, Repetitive cough, wheezing	____ Epi-pen _____Antihistamine
♦Heart*: Thready pulse, low blood pressure, fainting, Pale, Blueness	____ Epi-pen _____Antihistamine
♦Other*:_____	____ Epi-pen _____ Antihistamine
♦If reaction progressing (several areas affected), give:	____ Epi-pen _____ Antihistamine
(*Potentially life threatening)	

Dosage:

1. Epinephrine: inject intramuscularly ____Epi- Pen (0.3ml), _____Epi-pen , Jr. (0.15ml)

2. Antihistamine: Give _____
   Medication/ dose/ route

3. Other: Give _____
   Medication/ dose/ route

♦Step 2: Emergency calls♦

1. Call 911. State that an allergic reaction has been treated.

2. Dr._____ at _____(phone)

3. Emergency contacts: Name/ Relationship (los contactos de emergencia) — Phone Number(s) {los numeros de telefono}

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!

Parent/ Guardian signature: _____ Date: _____
(Crie firma)

Physicians's signature: _____ Date: _____
(Required)