

# WATERFORD UNION HIGH SCHOOL ALLERGY ACTION PLAN

Date \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

place  
child's  
picture  
here

ALLERGY TO: \_\_\_\_\_

## \*STEP 1: TREATMENT\*

### Symptoms:

### Give Checked Medication:

(To be determined by physician authorizing treatment)

* If insect bite/sting occurs, but <i>no symptoms</i> :	Epinephrine	Antihistamine	Other
* If food allergen has been ingested, but <i>no symptoms</i> :	Epinephrine	Antihistamine	Other
* Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine	Other
* Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine	Other
* Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine	Other
* Throat <sup>o</sup> Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine	Other
* Lung <sup>o</sup> Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine	Other
* Heart <sup>o</sup> Weak pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine	Other
* Other <sup>o</sup> _____	Epinephrine	Antihistamine	Other

The severity of symptoms can quickly change. <sup>o</sup>Potentially life-threatening

### DOSAGE

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

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**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 Numbers(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 \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physicians' Name (Printed) \_\_\_\_\_ Address \_\_\_\_\_ State/Zip Code \_\_\_\_\_

\*\*Adapted from The Food Allergy & Anaphylaxis Network. Used with permission.

