



Student's Name \_\_\_\_\_

School Year: \_\_\_\_\_ Date: \_\_\_\_\_

**1: List of foods and ingredients your child needs to avoid:**

**2: Complete the Allergy Action Plan Form** (at least 2 copies plus extra copies as needed for any other teachers with whom the child has contact, i.e., art, music, PE, library, computer). This form gives specific instructions about what to do if your child has an allergic reaction. You will need two or more small, recent photos of your child to attach to the copies of the form. One form will be kept in the office on file and the other copy will be kept with the medication. Forms must be signed by the child's attending physician.

**3: Provide all medication and instructions** for use in the original medication box or fanny pack that is clearly labeled with your child's name. Be sure to check the expiration dates and replace medications as needed.

**4: Provide a box of "safe snacks"** so there is always something for your child to choose from during unplanned special events or special occasions. Please label your child's name on the outside of the box.

Date list completed \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Signature of Teacher \_\_\_\_\_

Date \_\_\_\_\_

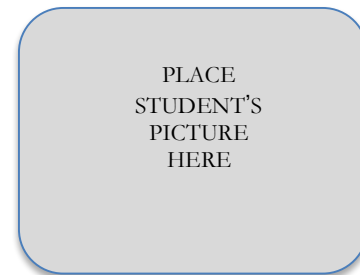
Form to be kept on file in the office

Student's Name \_\_\_\_\_

DOB \_\_\_\_\_ Teacher \_\_\_\_\_

Allergic to \_\_\_\_\_

Asthmatic  Yes\*  No \*Higher risk for severe reaction



STEP I: TREATMENT

Symptoms	Give Checked Medicine (To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but no symptoms	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth- Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin- Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut- Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat <sup>‡</sup> - Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung <sup>‡</sup> - Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart <sup>‡</sup> - Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other <sup>‡</sup> _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<sup>‡</sup> Potentially life-threatening. The severity of symptoms can quickly change		

DOSAGE

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

Antihastamine: 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 (or rescue squad: \_\_\_\_\_) State that an allergic reaction has been treated, and additional epinephrine may be needed.

Dr \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent \_\_\_\_\_ Phone Number \_\_\_\_\_

**Emergency Contacts:**

Name/Relationship \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Name/Relationship \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

**Even if a parent/guardian cannot be reached, DO NOT HESITATE to medicate or take student to medical facility!**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Required)