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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Give Checked Medicine (To be determined by physician authorizing treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a food allergen has been ingested, but no symptoms</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Mouth- Itching, tingling, or swelling of lips, tongue, mouth</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Skin- Hives, itchy rash, swelling of the face or extremities</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Gut- Nausea, abdominal cramps, vomiting, diarrhea</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Throatella- Tightening of throat, hoarseness, hacking cough</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Lungella- Shortness of breath, repetitive coughing, wheezing</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Heartella- Weak or thready pulse, low blood pressure, fainting, pale, blueness</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>Other#</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
<tr>
<td>If reaction is progressing (several of the above areas affected), give:</td>
<td>□ Epinephrine □ Antihistamine</td>
</tr>
</tbody>
</table>

# 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

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 (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)

Allergy Action Plan, revision 6.13.2018
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