GRACE
CHRISTIAN SCHOOL
Equipping Students for Life

ALLERGY ACTION PLAN

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

PLACE STUDENT'S PICTURE HERE

STEP I: TREATMENT

Symptoms	Give Checked Medicine (To be determined physician authorizing treatment)	
If a food allergen has been ingested, but no symptoms	□ Epinephrine	□ Antihistamine
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- Weak or thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
Other_____	□ Epinephrine	□ Antihistamine
If reaction is progressing (several of the above areas affected), give:	□ Epinephrine	□ Antihistamine
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)