St. Cyprian's
HEALTH SERVICES

ALLERGY ACTION PLAN

Student's Name:_____ DOB: ____/____/____ Homeroom:_____

Asthmatic: ○ No ○ Yes (Higher risk for severe reaction)

<>STEP 1: TREATMENT <>

Symptoms:	Give Checked Medication: **(To be determined by physician authoring 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, blue	○ 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®0.3mg Twinject®0.15mg

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 <>

1. Call 911, state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor:_____ Phone:_____
3. Parent: _____ Phone:_____
4. Emergency Contacts:
   a. _____ Phone:_____
   b. _____ Phone:_____

EVEN IF PARENT/GUARDIAN CAN NOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____