Monticello Public Schools Health Services

Allergy Action Plan

Student's Name:_____DOB:_____Teacher:_____

Allergy to:_____

Asthmatic Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

To be determined by physician authorizing treatment

Symptoms: Administer Checked Medication

- Mouth: Itching, tingling, or swelling of lips, tongue, mouth ___EpiPen ___Antihistamine
- Skin: Hives, itchy rash, swelling of face or extremities ___EpiPen __ Antihistamine
- Gut: Nausea, abdominal cramps, vomiting, diarrhea ___EpiPen __ Antihistamine
- Throat*: Tightening of throat, hoarseness, hacking cough ___EpiPen __ Antihistamine
- Lung*: shortness of breath, repetitive coughing, wheezing ___EpiPen __ Antihistamine
- Heart*: Thready pulse, low blood pressure, fainting, pale, blueness ___EpiPen __ Antihistamine
- Other*:_____ ___EpiPen __ Antihistamine
- If reaction progressing (several areas affected), give ___EpiPen __ Antihistamine

*Potentially life-threatening

Dosage:

1. Epinephrine: Inject intramuscularly ____EpiPen ____Antihistamine
2. Antihistamine: give_____
   Medication/dose/route
3. Other: give_____
   Medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State an allergic reaction has been treated.
2. Dr._____at_____
3. Emergency Contacts: Name/Relationship Phone Numbers
   a. _____ _____
   b. _____ _____
   c. _____ _____

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_____
(required)