FHUSD #98
ALLERGY ACTION PLAN

☐ McDowell Mtn. 480-664-5201 ☐ Four Peaks 480-664-5102 ☐ Middle School 480-664-5402 ☐ High School 480-664-5501

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO:_____

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

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication**** (** To be determined by 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† Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐Antihistamine
* Environmental allergies, any of the above	☐ Epinephrine ☐Antihistamine
* Other _____	☐ Epinephrine ☐Antihistamine
* If reaction is progressing (several of the above areas affected),give	☐ Epinephrine ☐Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

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. 911 will be called.

STEP 2: EMERGENCY CALLS

1. **Call 911.**

State that an allergic reaction has been treated, and additional epinephrine may be needed.

***** In case of an emergency, I give permission for the health office or other school personnel to contact the following people:*** ☐ ***Yes*** ☐ ***No***

2. Dr. _____ Phone Number: _____

3. Parents_____ Phone Number(s)_____

4. Emergency contacts:
Name/Relationship Phone Number(s)

a. _____ 1.)_____ 2.) _____

b. _____ 1.)_____ 2.) _____

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

Parent/Guardian Signature_____Date_____

Doctor's Signature_____Date_____

Revised 2010 (**Required**)