Allergy Action/Medication Plan

Part 2: To Be Completed By Health Care Provider

Place Student's Picture Here

Student's Name:_____ Date of Birth:_____

Allergy to:_____

Weight: _____lbs. Asthma: ☐ Yes (higher risk for severe reaction) ☐ No ☐ Asthma plan

Extremely reactive to the following:_____
THEREFORE:

☐ If checked, give epinephrine immediately for any symptoms if the allergen was likely eaten or injected (bee).

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion or contact:
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, cramping pain

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- INJECT EPINEPHRINE IMMEDIATELY (see back for auto-injection technique)
- Call 911
- Begin monitoring (see box below)
-Give additional medications as ordered below:
  -Antihistamine
  -Inhaler if asthma

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

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-GIVE ANTIHISTAMINE
-Stay with student, alert parent
-IF symptoms progress (see above), USE EPINEPHRINE
-Begin monitoring (see box below)

Medications/Doses
Epinephrine (brand and dose)_____
Antihistamine (brand and dose)_____
Other (i.e., inhaler-bronchodilator if asthmatic)_____

Monitoring: Stay with student. Alert the parent. Tell rescue squad epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given five minutes or more after the first if symptoms persist or recur. Consider keeping student in lying position with legs raised.

Authorization to administer above medication: _____ Parent Signature _____ Date

_____ Physician/Health Care Provider Signature _____ Date _____ Print Physician /Health Care Provider Name _____ Phone