SUNSET RIDGE SCHOOL DISTRICT 29
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Cultivating an inclusive learning community that engages the hearts and minds one child at a time.

ALLERGY AND ANAPHYLAXIS ACTION PLAN

Student's Name: _____

DOB: _____ Grade: _____

Allergy to: _____

Brief History: _____

Place child's Photo here

Asthma: ____ YES (higher risk for severe reaction) _____ NO

STEP 1 - TREATMENT

SYMPTOMS: GIVE CHECKED MEDICATION(S)			
➢Suspected ingestion or sting, but *no symptoms*		☐ Epinephrine	☐ Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort			☐ Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth		☐ Epinephrine	☐ Antihistamine
SKIN: Flushing, hives, itchy rash		☐ Epinephrine	☐ Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea		☐ Epinephrine	☐ Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough		☐ Epinephrine	☐ Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing	☐ Inhaler	☐ Epinephrine	☐ Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin		☐ Epinephrine	☐ Antihistamine
➢If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE:

Epinephrine: inject intramuscularly using autoinjector (circle one): 0.3mg 0.15mg
_____ administer second dose if symptoms do not improve in 15-20 minutes

Antihistamine: give (medication/dose/route) _____

Asthma Rescue (if asthmatic) give (medication/dose/route) _____

Student has been instructed and is capable of self-administering own medication: __ Y __ N

Provider Name: _____ Phone Number: _____

Provider's Signature: _____ Date: _____

STEP 2: EMERGENCY CALLS

1. If epinephrine given, call 911. State than an allergic reaction has been treated and additional epinephrine, oxygen, or other medication may be needed.

2. Parent: _____ Phone number: _____

3. Emergency contacts: Name/Relationship Phone numbers

   a. _____ _____

   b. _____ _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS.

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Allergy Care Plan for my child.

Parent/Guardian Signature: _____ Date: _____