HAMBURG CENTRAL SCHOOL DISTRICT
ALLERGY ACTION PLAN

Student's Name: _____ DOB: _____ GRADE: _____

ALLERGY : _____

Asthmatic? Yes* ☐ No ☐ *higher risk for severe reaction

**STEP 1: TREATMENT **

Symptoms:		Give Checked Medication (To be determined by physician)	
▪ If allergen ingestion/exposure but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
▪ Mouth:	Itching, tingling, or swelling of lips, tongue or mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin:	Hives, itchy rash, swelling of 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, repetive cough, wheezing	☐ Epinephrine	☐ Antihistamine
▪ *Heart:	Weak or thready pulse, low blood pressure, fainting	☐ Epinephrine	☐ Antihistamine
▪ *Other:	_____	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas) give:		☐ Epinephrine	☐ Antihistamine

*potentially life threatening: the severity of symptoms can quickly change

DOSAGE:
Epinephrine: inject intramusculary (circle one) EpiPen EpiPen Jr. Twinject 0.3 Twinject 0.15

Antihistamine: give _____

Other: give _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2 EMERGENCY CALLS

1. Call 911 (or rescue squad _____) State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr. _____ Phone Number _____
3. Parent _____ Phone Number_____
4. Emergency contacts: Phone Numbers:
   a. _____ _____
   b _____ _____

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

_____
PARENT/GUARDIAN SIGNATURE DATE

_____
PHYSICIAN SIGNATURE DATE

_____
SCHOOL NURSE DATE RECEIVED

6-09