



### Allergy Action Plan

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergy: \_\_\_\_\_

**Step 1: Treatment**

**Symptoms**

If a food allergen has been ingested but no symptoms	___ Epinephrine	___ Antihistamine
<b>MOUTH</b> – Itching, tingling, or swelling of lips tongue, mouth	___ Epinephrine	___ Antihistamine
<b>SKIN</b> – Hives, itchy rash swelling of the face or extremities	___ Epinephrine	___ Antihistamine
<b>GUT</b> - Nausea, abdominal cramps, vomiting, diarrhea	___ Epinephrine	___ Antihistamine
<b>THROAT*</b> - Tightening of throat, hoarseness, hacking cough	___ Epinephrine	___ Antihistamine
<b>LUNG*</b> - Shortness of breath, repetitive coughing, wheezing		
<b>HEART*</b> - Thready pulse, low blood pressure, fainting, pale, blueness	___ Epinephrine	___ Antihistamine
<b>OTHER*</b> If reaction is progressing (several of the above areas affected): give	___ Epinephrine	___ Antihistamine

\*Potentially life threatening, the severity of symptoms can quickly change.

DOSAGE:

Epinephrine: \_\_\_\_\_

Antihistamine: \_\_\_\_\_

Other: \_\_\_\_\_

Physician's Signature/Stamp

Date

Guardian/Parent Signature

Date