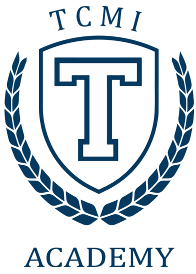

Allergy Action Plan

Name (Last, First, Middle) ______________________ Grade ________

School Year ______________ Date ______________

1) List of foods and ingredients your child needs to avoid:

2) Complete the Allergy Action Plan Form (Please make at least 2 copies plus extra copies as needed for any other teachers, assistants, volunteers, or agents of TCMI with whom the child has contact.)
This form gives specific instructions about what to do if your child has an allergic reaction. You will need two or more small, recent photos of your child to attach to the copies of the form. One form will be kept in the office on file and the other copy will be kept with the medication. All forms must be signed by the child's attending physician.

3) Provide all medication(s) and instructions for use in the original medication box or fanny pack that is clearly labeled with your child's name. Be sure to check the expiration dates and replace medications as needed.

4) Provide a box of "safe snacks" so there is always something for your child to choose from during unplanned special events or special occasions. Please label your child's name on the outside of the box.

Date List Completed: ______________________

Parent/Guardian Name (printed)	Parent/Guardian Signature	
Parent/Guardian Name (printed)	Parent/Guardian Signature	
Teacher Name (printed)	Teacher Signature	Date

Form to kept on file in the office

Student's Name ______________________________

DOB ____________________ Teacher ______________________

Allergic to: ______________________________

____

____

Asthmatic ___Yes* ___No * Higher risk for severe reaction

Step 1: Treatment

Symptoms	Give/administer circled medicine (to be determined by physician authorizing	
If 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**- Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other**-____	Epinephrine	Antihistamine
If reaction is progressing (affecting several above areas), give:	Epinephrine	Antihistamine
** Potentially life-threatening. The severity of symptoms can quickly change		

Dosage to be given/administered
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: Give ______________________________
(Medication/Dosage/Route of Administration

Other: Give ______________________________
(Medication/Dosage/Route of Administration

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

Step 2: Emergency Calls

Call 911 (or rescue squad:__________) State that an allergic reaction has been treated, and additional epinephrine may be needed.

Dr ______________________________ Phone Number ______________

Parent's/Guardian's Name ______________________ Phone Number ______________

Parent's/Guardian's Name ______________________ Phone Number ______________

Emergency Contacts (if parent cannot be reached)

Name/Relationship ______________________ Phone Number ______________

Name/Relationship ______________________ Phone Number ______________

Even if a parent/guardian cannot be reached, DO NOT HESITATE to medicate or take student to medical facility!

______________________ ______________________ __________
Parent/Guardian Name (printed) Parent/Guardian Signature Date

______________________ ______________________ __________
Parent/Guardian Name (printed) Parent/Guardian Signature Date

Doctor's Signature ______________________________ __________
(Required) Date

______________________ ______________________ __________
TCMI Staff Name (printed) TCMI Staff Signature Date