ALLERGY ACTION PLAN

*Must be accompanied by a Medication Authorization Form

Place child's picture here

CHILD'S NAME: _____ DOB:_____

ALLERGY TO:_____

Asthmatic: No_____ Yes_____(high risk for severe reaction)

SYMPTOMS:	**Give this Medication**	
The child has ingested a food or allergen or exposed to an allergy trigger:	Epinephrine	Antihistamine
But is **not** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat:* difficulty swallowing (choking feeling"), hoarseness, hacking cough		
Lung:* shortness of breath, repetitive coughing, wheezing		
Heart:* Weak or fast pulse, low blood pressure, fainting /"passing out", pale, blueness		
Other:		

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

Medication:	**Dose:**	
Epinephrine		
Antihistamine		
Other		

ACTION FOR ALLERGIC REACTION

- If ingestion is suspected and/or symptoms are:_____,

  give_____IMMEDIATELY!
- **CALL 911**. Tell them what medications you have already administered. **DO NOT HESISTATE TO CALL 911!**
- Call Parent 1:_____phone:_____ , Parent 2_____phone:_____,

  or emergency contacts: _____ phone _____or _____ phone _____
- Call Dr._____ phone:_____

_____ _____

Parent's Signature Date