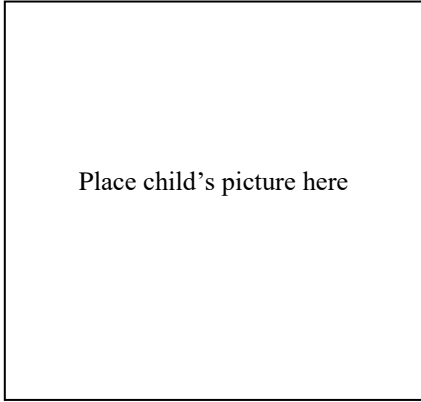


ALLERGY ACTION PLAN

*Must be accompanied by a Medication Authorization Form



CHILD'S NAME: _____ **DOB:** _____

ALLERGY TO: _____

Asthmatic: No _____ Yes _____ (high risk for severe reaction)

SYMPTOMS:	Give this Medication	
<i>The child has ingested a food or allergen or exposed to an allergy trigger:</i>	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 HESITATE TO CALL 911!**
- Call Parent 1: _____ phone: _____, Parent 2 _____ phone: _____, or emergency contacts: _____ phone _____ OR _____ phone _____
- Call Dr. _____ phone: _____

 Parent's Signature Date