Life Threatening Allergy Action Plan
Emergency Care Plan

Student: _____ID#: _____ Date of Birth: _____

Grade:_____ School Year:_____ Teacher: _____School: _____

Allergic to: _____

Place Child's Picture Here

Asthma: YES * ☐ **NO** ☐ ***Higher risk for severe reaction**

Body System	**Signs/Symptoms**
Throat*	Tightening of throat, hoarseness, hacking cough.
Lungs*	Shortness of breath, repetitive coughing, wheezing.
Heart*	Thready pulse, low blood pressure, fainting, pale, blue skin color.
Mouth:	Itching, tingling, swelling of lips, tongue, mouth.
Skin:	Hives, itchy rash, swelling of face or extremities.
Gut:	Nausea, abdominal cramps, vomiting, diarrhea.

*Potentially life threatening. The severity of symptoms can quickly change.

Step 1: Treatment

Epinephrine Auto-Injector: _____ Call EMS if given

Antihistamine: Give _____
Medication/Dose/Route

Other: Give _____
Medication/Dose/Route

Step 2: Emergency Calls

Once an Epinephrine Auto-Injector is used, call EMS (9-911).

Contacts: Parent/Guardian: _____, H:_____;W:_____;C:_____

Contacts: Parent/Guardian: _____, H:_____;W:_____;C:_____

Contacts: Alternative: _____, H:_____;W:_____;C:_____

Does this student have physician authorization to self-administer this medication and to carry this medication on himself/herself?

Yes ☐ **No** ☐

Other trained staff/location:

1._____

2._____

Date of Plan: _____

Physician's Signature: _____

Parent's Signature: _____

Nurse's Signature: _____

Revised 7/2015