Walton Verona Independent Schools

ALLERGY ACTION PLAN

Student's Name_____ **DOB**_____ **Grade**_____

ALLERGIC TO:_____

Asthmatic Yes _____ **No** _____ ****Makes student at higher risk for severe reaction****

***Student can carry and self-administer Epi Pen: YES**____ **NO**____

STEP 1: TREATMENT

Symptoms:

• If an allergen has been introduced but NO symptoms:	____ Epi Pen	____ Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	____ Epi Pen	____ Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	____ Epi Pen	____ Antihistamine
• Stomach: Nausea, abdominal cramps, vomiting, diarrhea	____ Epi Pen	____ Antihistamine
• Throat: Tightening of throat, hoarseness, hacking cough	____ Epi Pen	____ Antihistamine
• Lung: Shortness of breath, repetitive coughing, wheezing	____ Epi Pen	____ Antihistamine
• Heart: Thready pulse, low blood pressure, fainting, palor, Blueness (cyanosis)	____ Epi Pen	____ Antihistamine
• Other:_____	____ Epi Pen	____ Antihistamine

Epinephrine: inject intramuscularly (circle one) **Epi Pen** **Epi Pen Jr** **Dosage:**_____

Antihistamine:_____

Medication/Dose/Route

Other:_____

Medication/Dose/Route

STEP 2: EMERGENCY CALLS

1. **Notify parents of exposure.**
2. **If Epi Pen is used, MUST INITIATE 911.**
3. **Physician:**_____ **Phone number:**_____
4. **Emergency Contacts:**

   Name/Relationship **Phone number(s)**

   A._____

   B._____

   C._____

   *****If parent cannot be reached, child will be treated and transported to Medical Facility****

Parent/Guardian Signature_____ **Date**_____

Health Care Provider Signature_____ **Date**_____