

Allergy Action Plan Emergency Care Plan

Name: _____ D.O.B. ____ / ____ / ____

Allergy to: _____

Weight: _____ lbs Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any **SEVERE SYMPTOMS** after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
 HEART: Pale, blue, faint, weak pulse, dizzy, confused
 THROAT: Tight, hoarse, trouble breathing/swallowing
 MOUTH: Obstructive swelling (tongue and/or lips)
 SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
 GUT: Vomiting, diarrhea, crampy pain

**1- INJECT EPINEPHRINE
IMMEDIATELY**

- 2- Call 911
 3- Begin monitoring (see box below)
 4- Give additional medications*:
 -Antihistamine
 -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
 SKIN: A few hives around mouth/face, mild itch
 GUT: Mild nausea/discomfort

1-GIVE ANTIHISTAMINE

- 2- Stay with student; alert healthcare professionals and parent
 3- If symptoms progress (see above), USE EPINEPHRINE
 4- Begin monitoring (see box below)

Medications/Doses:

Epinephrine:

EpiPen/AuviQ 0.3 mg IM
 Or
 EpiPen Jr./AuviQ 0.15 mg IM

Antihistamine:

See weight chart on back

Other (e.g. inhaler-bronchodilator if asthmatic):

Albuterol or Xopenex
 4-8 puffs or 1-2 nebulizer treatments PRN

Monitoring

Stay with student; alert healthcare professionals and parents. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Travel

Please allow family to travel with above medications and to utilize them in the event of a food reaction.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

Date _____