Allergy and Anaphylaxis Action Plan

Student Name _____ DOB _____/_____/_____
Building_____ Grade_____ School Year_____/_____

Severity Classification: ☐ Mild ☐ Severe

Allergy to:_____

Asthma ☐ Yes (high risk for severe reaction) ☐ No

*Asthma inhalers and antihistamines cannot be depended on for a severe reaction, use epinephrine.

Mild Symptoms	
Itchy, runny nose	Itchy mouth
A few hives	Mild nausea
Discomfort	Other:
_____	_____

Severe Symptoms		
Shortness of breath	Difficulty breathing	Repetitive cough
Pale or blue skin	Feeling faint/dizzy	Weak pulse
Tightening of throat	Trouble swallowing	Swelling of lips/tongue
Hives over body	Widespread redness	Anxiety/bad feeling
Other:		

*Severity of symptoms can change quickly. These can become life threatening. Act fast.

To be completed by physician

Oral medication: _____
Medication Dose Frequency

(Check all that apply)

☐ Give if mild symptoms present with/without known exposure to allergen

☐ Give if possible exposure to allergen with/without symptoms

☐ Give if exposed to allergen and no symptoms are present

Epinephrine: _____ ☐ 0.15mg ☐ 0.3mg
Brand

(Check all that apply)

☒ Give if severe symptoms are present, regardless of known exposure

☐ Give if exposed to allergen and mild symptoms are present

☐ Give if known exposure to allergen even if symptoms are not present

If **severe symptoms** occur or if **epinephrine has been given**:

Give epinephrine dose listed above (if not already done)

Call 911 and MERT team

Call parent/guardian or emergency contact

Send used epinephrine injector with EMS

May need a second dose if symptoms do not improve or come back after 5 minutes

Provider Signature_____ Date_____/_____/_____
Provider Name_____ Phone_____

I have reviewed this plan with my child's physician. I understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety. I give permission for staff to treat my child and according to this plan above.

Parent/Guardian Signature_____ Date_____/_____/_____
Parent/Guardian Name_____ Phone_____/_____

**Must also fill out Medication Authorization Form(s) for each medication the child may need to take at school.