Allergy Action Plan

Name:________________________________ Date of Birth:______________

Allergies:____

At risk for severe allergic reactions to the following:

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Asthma: YES OR NO

Additional orders:

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If exposed to allergens please do:

STEP 1

1) Mild Symptoms- ex. itchy mouth, minimal hives nausea/discomfort & mild itching.

   A) Benadryl Dosage__________

      Other ____________________

   B) Alert healthcare professional & parent.

   C) Monitor child for at least 30 minutes for Improvement.

   D) If no improvement or symptoms progress, proceed To **STEP 2.**

STEP 2

2) Severe Symptoms - ex. Shortness of breath, face blue, dizziness, hives,

   1) Inject Epinephrine into thigh immediately

   2) Call 911!!!

   3) Call parents then call the school nurse.

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Physician Signature