Congregation Beth Ahabah Religious School
Allergy Action Plan

PLACE PHOTO HERE

Student's Name _____ D.O.B. _____ Weight _____ lbs.

Allergic to _____

Asthmatic? ☐ YES *(higher risk for severe reaction)* ☐ NO

STEP 1: TREATMENT

If Signs of Allergic Reaction are Present — Give Checked ☑ Medication as ordered below
(to be determined by MD/NP authorizing treatment)

If a food allergen has been ingested, but there are NO SYMPTOMS:		☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat	Tightening of throat hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other	_____	☐ Epinephrine	☐ Antihistamine
If reaction is getting worse *(several of the above areas affected)*, give		☐ Epinephrine	☐ Antihistamine

NOTE: The severity of the symptoms can change quickly and may be life threatening. Additional dose of Epinephrine may be needed.

DOSAGES

Epinephrine: Inject into outer side of thigh

☐ EpiPen®0.3mg ☐ EpiPen®Jr.0.15mg ☐ Twinject™0.3mg ☐ Twinject™0.15mg ☐ Auvi-Q0.3mg ☐ Auvi-Q0.15mg

Antihistamine: *(i.e. Benadryl)* give _____
Medication/Dose/Route

Other: *(i.e. inhaler)* give _____
Medication/Dose/Route

STEP 2: EMERGENCY CALLS

☐ **1. Call 911.** Ask for advanced life support. State that an allergic reaction has been treated and additional epinephrine may be needed.

☐ 2. Dr. _____ Phone _____

☐ 3. Emergency Contacts
Name/Relationship — Phone number(s)

a. _____ a1 _____ a2 _____

B. _____ B1 _____ B2 _____

☐ **EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND SEND CHILD TO A MEDICAL FACILITY!**

Parent/Guardian Signature _____ Date _____
Required

Healthcare Provider's Signature _____ Date _____
Required