TRADERS POINT CHRISTIAN SCHOOLS

TRAINING SCHOLARS. MAKING DISCIPLES. GRADUATING LEADERS.

Allergy Medical Action Plan

Student Name: _____ DOB: _____

Teacher/Grade: _____

Allergy(s):_____

Asthma diagnosis: ☐ YES ☐ NO

STEP 1: Treatment

Symptoms	Give Checked Medication* *To be determined by physician authorizing treatment	
If allergen has been ingested, but no symptoms	☐ Antihistamine	☐ Epinephrine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine	☐ Epinephrine
Skin: hives, itchy rash, swelling of the face or extremities	☐ Antihistamine	☐ Epinephrine
Gut: nauesa, abdominal cramps, vomiting, diarrhea	☐ Antihistamine	☐ Epinephrine
Throat: tightening of throat, hoarseness, hacking cough	☐ Antihistamine	☐ Epinephrine
Lungs: shortness of breath, repetitive coughing, wheezing	☐ Antihistamine	☐ Epinephrine
Heart: thready pulse, low blood pressure, fainting, pale, blueness	☐ Antihistamine	☐ Epinephrine
Other:	☐ Antihistamine	☐ Epinephrine
If reaction is progressing (several of the above areas affected)	☐ Antihistamine	☐ Epinephrine

THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY AND BECOME POTENTIALLY LIFE-THREATENING

Medication and Dosage:

Antihistamine:_____
(name, dose and route)

Ephinephrine:_____
(name, dose and route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

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STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be required.
2. Emergency Contacts:

	Name/Relationship:	Number:
a.	_____	_____
b.	_____	_____

Even if a parent/guardian cannot be reached, do NOT hesitate to medicate or take child to a medical facility.

If it is deemed appropriate for this student to self-carry medication, an Authorization for Students to Carry Prescription/OTC Medication form will need to be filled out and signed by the physician, student and parent/guardian.

Healthcare Provider Name:_____

Healthcare Provider Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Reviewed by School Nurse:_____ Date:_____