TIMBERLANE SCHOOL DISTRICT
EMERGENCY ALLERGY ACTION PLAN

PLACE CHILD'S PICTURE HERE

ALLERGY TO: _____ **ID Bracelet: Yes___No____**

Student's Name: _____ DOB_____ Grade_____

Asthmatic: □ Yes* □ No *High risk for severe reaction Teacher _____

Nut Sensitive Table □ Yes □ No □N/A _____/_____Parent/MD initials
Nut Sensitive Class: □ Yes □ No □N/A _____/_____Parent/MD initials

♦TREATMENT♦

Symptoms: Give Checked Medication:

♦ If food allergen has been ingested/exposed to allergen/insect sting: but no symptoms	□ Epinephrine	□ Antihistamine
♦MOUTH itching, tingling or swelling of the lips, tongue, mouth	□ Epinephrine	□ Antihistamine
♦THROAT* itching, tightness in the throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
♦SKIN hives, itchy rash, swelling of the face or extremities	□ Epinephrine	□ Antihistamine
♦GUT nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□ Antihistamine
♦LUNG shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
♦HEART thready pulse, fainting, low blood pressure, pale or blue color	□ Epinephrine	□ Antihistamine
♦If reaction is progressing (several of the above areas affected	□ Epinephrine	□ Antihistamine

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life threatening situation.

DOSAGE:

Epinephrine: Inject intramuscularly (circle one) 0.3mg EpiPen .15 mg EpiPen (Jr)

Antihistamine: _____
Medication/dose/route

Other: give _____
Medication/dose/route

CALL EMS 911 (ask for advanced life support)

Name: **Phone**

1._____ (Parent/Guardian)

2._____ (Other emergency contact)

3. Dr. _____ (Physician)

Parent signature _____ Date _____

Doctor signature _____ Date _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR TO CALL EMS (911) EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

6/2/15