CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES

ALLERGY ACTION PLAN

Student's Name_____ D.O.B. _____Teacher/ Grade_____

ALLERGY TO: _____

Asthmatic? Yes* No * higher risk for severe reaction

STEP 1:	**TREATMENT SYMPTOMS:**	**Give Checked:**
> If a food allergen has been ingested, but *no symptoms*		_Epinephrine__Antihistamine
> Mouth	Itching, tingling, or swelling of lips, tongue, mouth	_Epinephrine__Antihistamine
>Skin	Hives, itch 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, blueness	_Epinephrine __Antihistamine
> Other+_____		_Epinephrine __Antihistamine
> If the reaction is progressing (several of the areas affected), give:		_Epinephrine_ Antihistamine

The severity of symptoms can quickly change. +Potentially life-threatening.

Do you want your child to eat at a Designated Peanut Free Lunch Table? Yes _____ No_____

EPINEPHRINE: Inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg.

ANTIHISTAMINE: give _____
medication/dose/route

OTHER: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1) CALL 911, State that an allergic reaction has been treated and additional epinephrine may be needed.

2) Dr._____ at _____

3) Emergency Contacts: Name Relationship Phone Number

a._____1)_____2)_____

b._____1)_____2)_____

If student carries the Epi-pen he/she has been instructed in its use and will report to the Health Office after using. We understand that a **911 call** is required after the Epi – pen is administered.

Doctor signature_____ Date: _____
(required)

Parent signature_____ Date: _____
(required)

1/09