BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

ALLERGY ACTION PLAN

Student's Name: ________________________________ **D.O.B:** ____________________

ALLERGY TO: ____

Asthmatic Yes* ☐ No ☐ * Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication**:** ** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but no symptoms:	☐ Epinephrine	☐ Antihistamine
• Mouth Itching, tingling, or swelling if 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 progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject ™ 0.3 mg Twinject ™ 0.15 mg
(see reverse side for instructions)

Antihistamine: give ____
medication/dose/route

Other: give ____
medication/dose/route

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

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: ____________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ______________________________ Phone Number: ________________ at ________________

3. Parents ________________________________ Phone Number(s): ____________________________________

4. Emergency contacts:

Name/relationship Phone Number(s)

a. __________________________________ 1. ______________________ 2. ________________________

b. __________________________________ 1. ______________________ 2. ________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature ____ Date _________________

Doctor's Signature ____ Date ___________________
(Required)