Epipen Food & Bee Sting Allergy Action Plan

Student's Name _____ DOB:_____

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 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

The severity of symptoms can change quickly ++potentially life-threatening

Medication Dosage

Epinephrine: Inject intramuscularly (Circle One) Epi-pen 0.3mg Epi-pen Jr 0.15mg Twinject 0.3mg Twinject 0.15mg

Antihistamine: give _____
Medication Dose Route

Other: give _____
Medication Dose Route

STEP 2: EMERGENCY CALLS

1. Call **911** or Rescue Squad: **609-896-1111** **State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Dr._____ Phone:_____
3. Emergency Contacts:

Name/Relationship	Phone Numbers	Home	Cell	Work
a._____				
b._____				
c._____				

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

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
Required