Life-Threatening Allergy Management Plan

Valid for Current School Year _____

Name: _____ **DOB:** _____

Allergy to: _____

Asthma: ☐Yes* ☐No *High risk for severe reaction ☐yes ☐ no ☐ Asthma Action Plan

It is medically necessary for student to carry epinephrine during school hours ☐Yes ☐No

Signs of an Allergic Reaction Include:

Systems:	Symptoms:
MOUTH	Itching and swelling of the lips tongue or mouth
THROAT	Itching and or a sense of tightness in the throat, hoarseness and hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive cough and/or wheezing
HEART	"thready pulse", "passing-out"

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

Action for a Minor Reaction:

1. If ingestion is suspected and/or symptom(s) are: *minor itching "and/or" mild hives to skin give*:

Liquid Benadryl (or generic dephenhydramine) **Dose:** _____

by mouth now and every 4-6 hours as needed.

2. Call Mother at _____ Father at _____ or emergency contact.
3. Call Dr. _____ at _____ to make physician aware of child's reaction.

If condition worsens or does not improve within 10 minutes follow steps for MAJOR Reaction below:

Action for a Major Reaction:

1. If symptom(s) are large amount of hives, throat swelling, cough, difficulty breathing, wheezing, vomiting, diarrhea or if symptoms progress after Benadryl is given, give:

☐ **-Epinephrine: inject intramuscularly:** (check below)

☐ Epipen® ☐ Epipen® Jr ☐ Twinject ™ 0.3mg ☐ Twinject ™ 0.15mg

☐**-Liquid Benadryl**: dose: _____ every 4-6 hours as needed (if able to tolerate liquids)

☐ **-Albuterol /or quick relief inhaler:** 2 puffs with spacer now (IF asthmatic)

Give above now then call:

2. **Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT**
3. **Repeat dose of Epinephrine if no improvement in 5-10 minutes**
4. Call Mother at _____ Father at _____ or emergency contact.
5. Call Dr. _____ at _____ to make physician aware of child's reaction.

_____ _____ _____ _____

PARENTS SIGNATURE **DATE** **DOCTOR'S SIGNATURE** **DATE:**

Print MD Name: _____

6/10

Address: _____