Allergy Action Plan

This form must be completed by a physician and signed by the parent annually for any student requiring epinephrine or an inhaler while at PrimeTime.

Child's Name: ________________________________ Date of Birth: _____________

Allergy To: ____

Asthmatic? YES ☐ NO ☐

TREATMENT – To be completed by a physician:

Body Location Symptoms:	Give Checked Medication:	
If a food allergen has been ingested or student Has been stung by an insect (if order is for insect Sting allergy), 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
General: Panic, sudden fatigue, chills, fear	☐ Epinephrine	☐ Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*: Weak or thread pulse, passing out, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*: ____	☐ Epinephrine	☐ Antihistamine

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

MEDICATION & DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinjet

Antihistamine: Medication, dose, route:

____

Other: Medication/Dose:____

CALL 911: Sate a student had a severe allergic reaction and additional epinephrine may be needed. Please send paramedics. Transport to the nearest hospital. Call the parents.

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

Doctor's Signature ____ Date _____________________

OVER ➡

EMERGENCY CALLS

The following is information is to be completed by the parent/guardian:

1. **CALL 911: Sate a student had a severe allergic reaction and additional epinephrine may be needed. Please send paramedics. Then call the parents.**
   Parent/Guardian: _______________________ Phone Number: _________________________________

   Parent/Guardian: _______________________ Phone Number: _________________________________

2. Emergency Contacts (we will call only if we could not get in touch with parent/guardians listed above)

Name	Relationship to child	Phone Number
___________________________	_____________________________	_______________________
___________________________	_____________________________	_______________________

3. Dr. ___________________________________ Phone Number:___________________________________

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

I hereby give permission for my child, ____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director designee. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medication.

____ ______________
Signature of Parent/Guardian Date