Medical Action Plan

Child's Photo Here

Student's Name:_____**D.O.B**:_____

ALLERGY TO:_____

Asthmatic: ____**Yes** (Higher Risk for Severe Reaction) ____ **No**

Medical Condition:_____

How Does this affect your child in the classroom:_____
_____

How may we offer the best classroom experience for your child: _____
_____

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† Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other		
Other		
If reaction is progressing (several of the above areas affected), give:	Epinephrine	Antihistamine

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

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: _____
3. Parent_____ 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's Signature_____ Date_____

Doctor's Signature_____ Date_____

(Required).