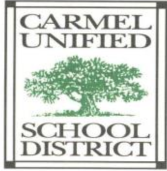

CARMEL UNIFIED SCHOOL DISTRICT- HEALTH SERVICES

ALLERGY ACTION PLAN

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

STUDENT NAME:____ DOB:________________________

PARENT/GUARDIAN:____________________________________ PHONE:_____________________________

OTHER EMERGENCY CONTACT:_________________________ PHONE:_____________________________

TREATING PHYSICIAN:__________________________________ PHONE:_____________________________

ALLERGY TO:____

Asthmatic Yes ☐ No ☐

Symptoms:		Give Checked Medication:	
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
Digestive:	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:		Epinephrine	Antihistamine

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

STEP 1: TREATMENT

Epinephrine (circle one) EpiPen EpiPen Jr. Auvi-Q 0.1mg Auvi-Q 0.15mg Auvi-Q 0.3mg

Antihistamine give:____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Contact Parents

Parent/Guardian's Signature____ Date__________________________

Doctor's Signature____ Date__________________________

Revised 8/13/18